61ST ANNUAL MEETING • COLISEUM • NEW YORK • AUG. 24-27

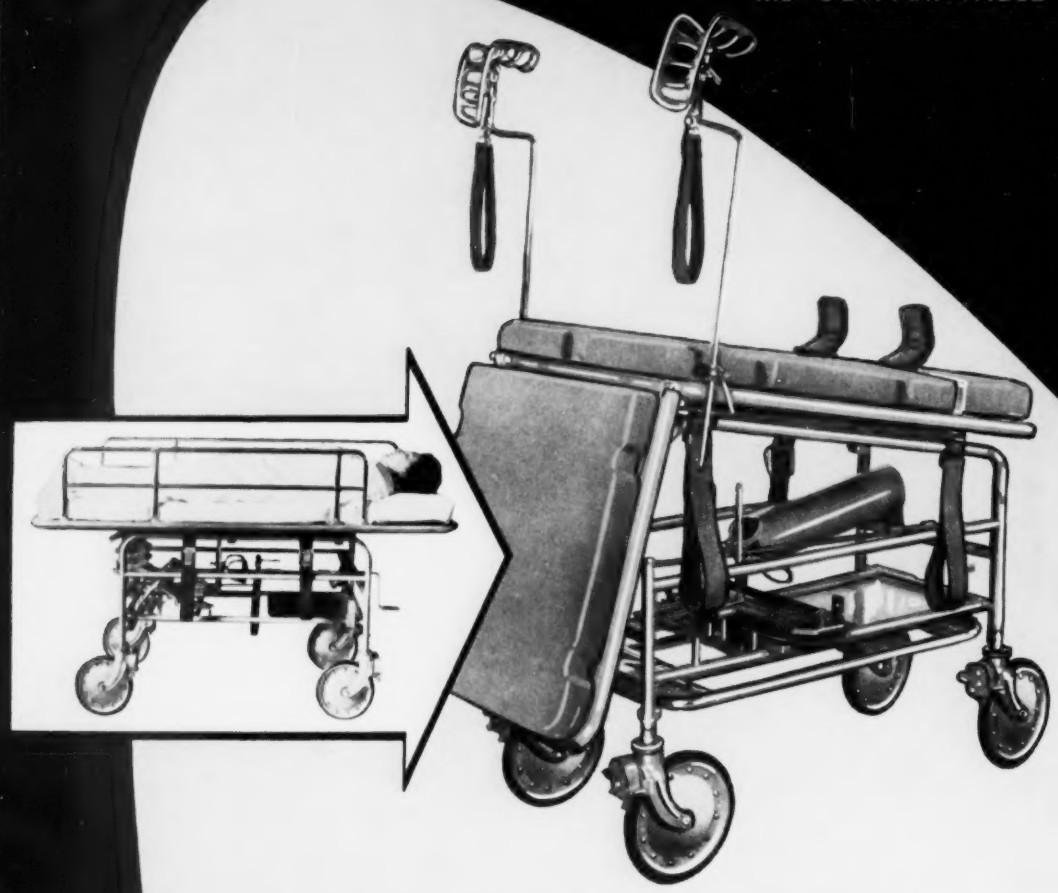
HOSPITALS

JOURNAL OF THE
AMERICAN
HOSPITAL
ASSOCIATION

AUGUST 16, 1959

HOSPITAL CONDUCTS COURSE FOR BABY SITTERS

the CONVER-TABLE

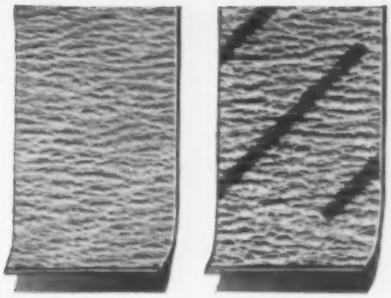


A WHEEL STRETCHER SPECIFICALLY DESIGNED FOR THE *OBSTETRICAL DEPARTMENT*

This wheel stretcher with its exclusive "break top" is a real asset to any obstetrical department. It can be converted from a stretcher to an OB examining table in a matter of seconds. Although basically a stretcher, the numerous special features of the CONVER-TABLE have made it what many have referred to as "the most versatile stretcher in today's market." It lends itself to a maximum variety of applications, alowing this unit to replace several pieces of equipment. The Conver-table is ideally suited for an OB examining table, labor bed and OB recovery stretcher. This unit, when necessary, can even be conveniently used for labor, delivery and recovery without transferring the patient. The Conver-table is a valuable adjunct to any obstetrical department.

The Hausted Manufacturing Co

MEDINA, OHIO



Before Autoclaving

After Autoclaving

You're sure with "SCOTCH" BRAND

Hospital Autoclave Tape No. 222

WON'T POP LOOSE even in high steam temperatures. "SCOTCH" Brand Hospital Autoclave Tape No. 222 sticks at a finger touch. Seals linen or paper packs quickly, *surely*. Peels off clean, leaving no stains or gummy residue. You can even write on it with pencil, ink or typewriter.

SPECIAL INKS in "SCOTCH" Hospital Autoclave Tape No. 222 *can't* be accidentally activated by sunlight, radiator heat or a dry air pocket in a faulty autoclave. Only correct levels of heat AND moisture can make these distinctive markings appear. And you can see them across a room!

SCOTCH BRAND Hospital Tapes

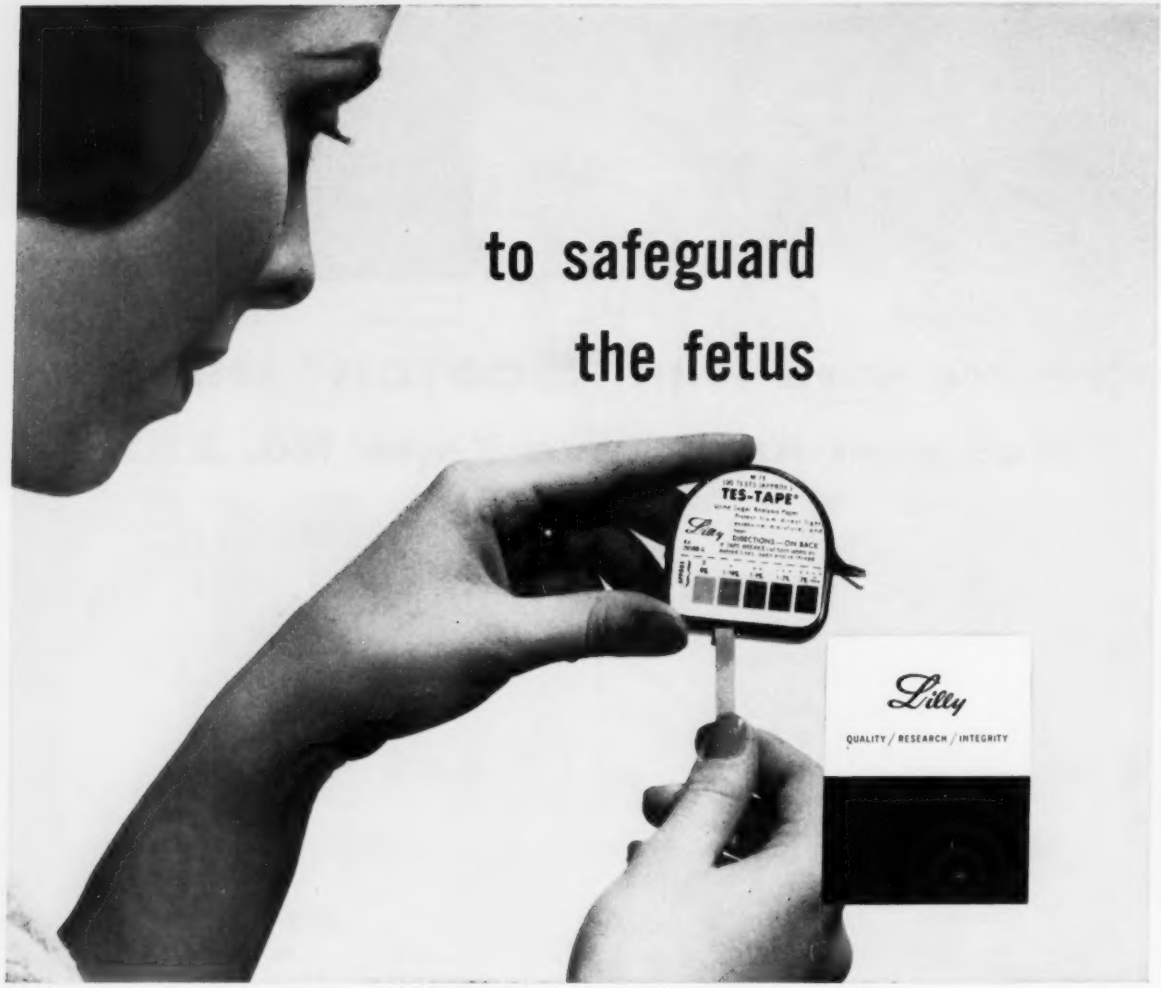
REG. U.S. PAT. OFF.

"SCOTCH" is a registered trademark for the pressure-sensitive adhesive tapes of 3M Co., St. Paul 6, Minn. Export: 99 Park Ave., New York 16. Canada: London, Ontario.

MINNESOTA MINING AND MANUFACTURING COMPANY

...WHERE RESEARCH IS THE KEY TO TOMORROW

3M COMPANY



TES-TAPE®. . . helps detect the pregnant "pre-diabetic"

". . . fetal mortality in the unrecognized diabetic may be as great as, if not greater than, in the known diabetic."[1] Therefore, it is vital to find the "pre-diabetics" by frequent blood and urine testing.

Because of its greater sensitivity and specificity, the glucose oxidase (Tes-Tape) method of urine glucose determination has been recommended[2,3] for use during pregnancy in preference to copper-reducing methods. Fructose, galactose, and lactose in the urine of pregnant women give false positive reactions with copper-reduction tests.

These sugars will not affect Tes-Tape, however; Tes-Tape is specific for glucose. Moreover, because Tes-Tape is more sensitive, it detects even minute quantities of glucose. Thus, you can discover the glycosuria earlier and institute further studies and corrective measures more promptly.

1. Shlevin, E. L.: Pregnancy and Diabetes, Diabetes, *6*:523, 1957.
2. Wilkerson, H. L. C.: *Ibid.*
3. Whitehouse, F. W., *et al.*: Management of the Pregnant Diabetic, M. Times, *86*:833, 1958.

Tes-Tape® (urine sugar analysis paper, Lilly)

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

HOSPITALS

Journal of the American Hospital Association

Volume 33 **Number 16** **August 16, 1959**

editor
Edwin L. Crosby, M.D.

executive editor
James E. Hague

managing editor
Rex N. Olsen

assistant editors
Maria B. Grygier
William McKillop
Barbara E. Monahan
Charlotte M. Roller

production manager
Newton J. Jacobson

advertising production manager
Martha E. Miller

controller
John E. Sullivan

sales manager
Bremen I. Johnson

sales promotion manager
Hal Levinson

circulation manager
Dorothy Heller

STAFF CONSULTANTS

J. R. Anderson, M.D.
Arthur H. Bernstein
Robert S. Borczon
Madison B. Brown, M.D.
Jack D. Dillman
Marian L. Fox, R.N.
Jose Gonzales, M.D.
Richard L. Johnson
Ruth M. Kahn
John T. Kelly
Eleanor C. Lambertsen, Ed.D.
Edmond J. Lanigan
Marjorie M. Lawson
Bryan Lovelace Jr.
James A. Mahoney, M.D.
Robert S. Marshall
Helen D. McGuire
Roger C. Mellem
William T. Middlebrook Jr.
Maurice J. Norby
Joseph A. Oddis
Jack W. Owen
Daniel S. Schechter
William E. Sheehan
Ko Shih, Ph.D
Hiram Sibley
Patricia Sussmann
Elton TeKolste
Vernon E. Weckwerth
Gerald A. Weidemier
Alanson W. Willcox
Kenneth Williamson
Helen Yast

articles

A Balanced Hospital Community — *Thomas McKeown, M.D.* — 40
Hospital Conducts Course for Baby Sitters — *Albin Oberg* — 45
Today's Practical Nurse
1. Concepts Behind Her Education — *Hilda M. Torrop* — 46
2. How She Is Filling the Nursing Gap — *Cordelia W. Kelly* — 47
'Opal 58'—Surprise 'Paper Evaluation' Moves 13 Hospitals to Non-Target Area — *Jerry N. Ransohoff* — 51
Painless Renovation — *G. O. Lindgren* — 54
Tuberculocidal Properties of Four Hospital Disinfectants — *Edward E. Vicher, Ph.D., and Milan V. Novak, M.D.* — 61
Quick Way to Measure Laundry Output Per Manhour — *F. G. Breusch and James L. Blackburn* — 68
Why One Hospital Switched to Disposable Syringes and Needles — *Steve J. Soltis* — 72
Good Food—A Public Relations Plus — *Mrs. Elizabeth E. Halleck* — 83

departments

Food Service and Dietetics — 83
Laundry-Housekeeping — 68
Professional Practice — 61
Purchasing — 72

regular features

Accreditation Problems — *Kenneth B. Babcock, M.D.* — 27
Book Reviews — 66
Calendar of Association and Allied Meetings — 6
Digest of News — 17
Editorial Notes — 39
Equipment and Supply Review — 76
Introducing the Authors — 13
News — 97
Opinions and Ideas — 30
Personnel Changes — 58
Pro Re Nata — *John H. Hayes* — 110
Service from Headquarters — 36
Washington Report — 91

cover

Teen-age baby sitters learn the proper way to change a diaper in a course for baby sitters conducted by Clara Maass Memorial Hospital, Belleville, N.J. An article by the executive director of the hospital, Albin Oberg, describing the way the course prepares teen-agers for adult responsibilities begins on page 45.

Classified Advertising — 111
Index to Advertisers — 112

HOSPITALS is published the first and sixteenth of each month by the American Hospital Association, 840 North Lake Shore Drive, Chicago 11, Ill. Tel: WHitehall 4-4350. Second-class postage paid at Chicago, Illinois. SUBSCRIPTION RATES: $5 for 1 year; $12 for 3 years. Single copies, 30 cents, except the two-part August 1, Guide Issue, $2.50 (Foreign and Pan-American add $1 per year for postage.) CHANGE OF ADDRESS: Notice should include the old as well as the new address including postal zone number. Four weeks' notice is required. The local postmaster should be notified.

COPYRIGHT: 1959, by the American Hospital Association.

ADVERTISING REPRESENTATIVES

Chicago 11: *Eli Fritz, 840 North Lake Shore Drive—WHitehall 4-4350*
Chicago 11: *William W. Howe, 840 North Lake Shore Drive—WHitehall 4-4350*
Cleveland 15: *Eugene C. Leipman, 1220 Huron Rd.—SUperior 1-1373*
New York 22: *George B. Janco, 3 E. Fifty-fourth St.—PLaza 4-1090*
Pasadena: *Ren Averill, 232 N. Lake Ave.—RYan 1-9291*
Pasadena: *Earl A. Jackson, 232 N. Lake Ave.—RYan 1-9291*

B.F.Goodrich

An extra-soft rubber glove that reduces hand fatigue, fits comfortably without binding

Softer than other gloves; stronger and just as thin

"Less tiring to my hands", "Doesn't restrict my fingers", ". . . almost forgot I had gloves on", are typical comments made by surgeons who are using "Surgiderm" gloves, developed by B.F.Goodrich.

Testing machines—which measure the softness and strength of rubber—prove that the "Surgiderm" glove is 30 to 50 per cent *softer* than any regular rubber surgeon's glove. This means that it is:

Less tiring to the hands

Because it's more pliable, it fits easily, snugly—doesn't bind the hand or restrict the freedom of the fingers. Less force is needed to flex the fingers and that's what reduces hand fatigue. The difference is so obvious you can feel it just by putting the B.F.Goodrich "Surgiderm" glove on one hand and comparing it with any other rubber glove on your other hand.

Permits sensitive touch

The glove is tissue thin all over—no heavy ends at fingertips. This allows almost as sensitive a touch as a surgeon would have without gloves.

Stronger, longer lasting

The use of a specially-developed rubber compound makes this B.F.Goodrich glove extra strong to start with and it stays strong even after a dozen sterilizations.

Test a pair

Ask the glove buyer at your hospital to get a pair of B.F.Goodrich "Surgiderm" gloves for you. We think when you compare them with the gloves you are now using, you'll be convinced that these B.F.Goodrich gloves are the most comfortable you've ever worn.

They cost no more

Since this glove is the only one that combines comfort and sensitivity with strength—you might expect it to be expensive. The fact is it costs no more than many regular rubber gloves being sold today. In the long run, it really costs less because it can be used for more operations.

Where to buy

B.F.Goodrich "Surgiderm" gloves are made in sizes from 6 to 10, are brown in color. Try a pair soon. They're sold by hospital supply houses and surgical dealers everywhere. *Hospital and Surgical Supplies Dept., B.F.Goodrich Industrial Products Co., Akron 18, Ohio.*

B.F.Goodrich ***hospital and surgical supplies***

(Advertisement)

Take a Close Look at Hospital Injectables

Reading time: 2½ minutes Benefits: 12

There is little doubt that disposable equipment has assumed great importance in the modern hospital. Certainly, no hospital administrator would dispute the fact that disposable items such as knife blades, blood lancets, urine collection bags, catheters, and enemas all help increase efficiency and, often, cut costs.

On the other hand, much can be said for equipment of a more permanent nature. Personnel have usually had experience with it. There's no need for constant re-ordering; the cupboard is rarely bare.

You can have both

The advantages of disposable and permanent equipment do not necessarily have to be separate and distinct. In the TUBEX® closed-system of injectables, for example, the best features and advantages of both are combined. The system comprises a durable, finely made syringe and a disposable cartridge (glass) and needle unit containing a pre-measured dose of medication.

Injection with TUBEX *simply requires that the proper pre-filled cartridge-needle unit be selected, inserted in the syringe, and aspirated. After the injection has been given, the cartridge-needle unit is discarded; the syringe is ready to use again . . . and again . . . and again . . .*

The benefits that the TUBEX system brings to hospital personnel, and the contributions that it makes to hospital efficiency and the welfare of patients, are impressive. Consider, if you will, the following examples.

1. Accurately measured dose assured
2. Danger of giving wrong drug reduced

Each sterile cartridge-needle unit contains an accurate, clearly labeled dose. Therefore, the nurse no longer must measure out doses as before—perhaps from an often-used, possibly contaminated multiple-dose vial. She runs little risk of administering an inaccurate dose or, worse yet, the wrong drug entirely. Obviously, the less chance for error the fewer the number of malpractice suits.

3. Efficiency of Central Supply increased
4. Breakage losses reduced

TUBEX cartridge-needle units are pre-sterilized; the needles pre-sharpened. This means that Central Supply can turn its attention to duties other than the time-consuming sterilization of syringes and the sharpening and sterilization of needles. It also means that breakage, which invariably accompanies these operations, and which raises the hospital's costs, is drastically reduced.

5. A source of hepatitis eliminated
6. Contact sensitization minimized

TUBEX cartridge-needle units serve for a single injection only. There can be no contaminated needles to transmit serum hepatitis or other diseases. Also, because there is virtually no chance for spillage, the nurse rarely comes into contact with drugs that might produce dermatitides or be absorbed to cause even more serious effects.

7. Inventory control simplified
8. Narcotic security tightened

The TUBEX system requires only two parts, half as many as the "conventional" system.

TUBEX System: cartridge-needle unit, syringe
Conventional System: plunger, barrel, needle, medication

There are fewer records to keep. Inventory control, therefore, is more accurate and efficient. As inventory control becomes more accurate, narcotic security automatically tightens.

9. Patients react more pleasantly to injections
10. Most commonly used drugs available

The most obvious direct benefit that the TUBEX system provides for the patient is a relatively painless injection, the result of a fresh, pre-sharpened, single-use needle. Since most common drugs—and many uncommon ones as well—are available in TUBEX form, the majority of hospital patients can benefit from the TUBEX system.

11. Accounting made more efficient
12. Billing made more accurate

Since each cartridge-needle unit contains a single, pre-measured dose, the amount of medication, including narcotics, that is given a patient is readily ascertainable. Hence, accounting is facilitated and the proper charges to the patient can be made accurately and easily.

In summary

As you can see, adoption of the TUBEX system can have far-reaching effects. Efficiency and morale of the staff are improved. Labor costs—currently about 70 cents of every dollar spent by the hospital—are markedly reduced. Accounting, billing, and inventory control are made more accurate. The risk of malpractice suits is mitigated. The well-being of patients is enhanced.

The TUBEX system can presently supply more than 75 per cent of injectables commonly administered in hospitals. And medications not yet available in TUBEX form can be administered by means of empty, sterile cartridge-needle units. Thus, the TUBEX system is capable of meeting every need for injectables.

The TUBEX system is already in wide use. To learn more about the many benefits that the TUBEX system can bring to *your* hospital, please see your Wyeth Territory Manager or write to Wyeth Laboratories, P.O. Box 8299, Philadelphia 1, Pa.

hospital association meetings

AMERICAN HOSPITAL ASSOCIATION NATIONAL MEETINGS

1959

Aug. 24-27—**61st annual meeting,** New York City (Coliseum; Statler Hilton Hotel)

1960

Aug. 29-Sept. 1—**62nd annual meeting,** San Francisco (Civic Auditorium)

MEETING AND INSTITUTE CALENDAR

THROUGH DECEMBER 1959

(American Hospital Association institutes are in BOLDFACE type. Meetings of other hospital associations are in LIGHTFACE type. ***Other organizations in the health field are shown in ITALICS.)***

AUGUST

17-18 ***American Society of Hospital Pharmacists,*** Cincinnati (Netherland Hilton Hotel)

18-21 ***American Pharmaceutical Association,*** Cincinnati (Netherland Hilton Hotel)

22 ***American Association of Hospital Consultants,*** New York City (Statler Hilton Hotel)

22-23 ***American Association for Hospital Planning,*** New York City (Governor Clinton Hotel)

23-26 ***American College of Hospital Administrators,*** New York City (Statler Hilton Hotel)

24-27 ***American Association of Nurse Anesthetists,*** New York City (New Yorker Hotel)

25-28 ***American Dietetic Association,*** Los Angeles (Shrine Auditorium)

SEPTEMBER

3-9 ***American Psychological Association,*** Cincinnati

9 Associated Hospitals of Manitoba, Winnipeg (Royal Alexandra Hotel)

12-14 Minnesota Hospital Association, Pequot Lakes (Breezy Point Lodge)

14-16 Montana Hospital Association, Great Falls (Rainbow Hotel)

14-18 ***American Dental Association,*** New York (Coliseum)

21-24 **Operating Room Administration,** Denver (Cosmopolitan Hotel)

22-25 ***American Roentgen Ray Society,*** Cincinnati (Netherland Hilton Hotel)

23 Utah State Hospital Association, Salt Lake City

27-Oct. 2 ***American College of Surgeons, Clinical Congress,*** Atlantic City (Convention Hall)

28-Oct. 2 **Housekeeping and Laundry,** Chicago (AHA Headquarters)

28-Oct. 2 **Medical Social Workers in Hospitals,** Atlanta (Henry Grady Hotel)

OCTOBER

1 Hospital Association of Rhode Island, Providence (Sheraton-Biltmore Hotel)

5-8 ***American Academy of Pediatrics,*** Chicago (Palmer House)

5-8 **Nursing Service Supervision,** Boston (Somerset Hotel)

5-9 ***American Society of Anesthesiologists,*** Bal Harbour, Fla. (Americana Hotel)

6-8 ***American Nursing Home Association,*** Chicago (Morrison Hotel)

7-9 **Hospital Librarianship,** Chicago (AHA Headquarters)

8-9 Arizona Hospital Association, Flagstaff (Monte Vista Hotel)

8-9 Colorado Hospital Association, Colorado Springs (Antlers Hotel)

8-9 Mississippi Hospital Association, Biloxi (Hotel Buena Vista)

12-15 **Supervision,** Atlanta (Henry Grady Hotel)

12-15 ***American Association of Medical Record Librarians,*** Minneapolis (Radisson Hotel)

14-15 Indiana Hospital Association, Indianapolis (Student Union Building)

(Continued on page 106)

for bacteriostatic dust control

Ordinary untreated dustcloths pick up many harmful organisms and permit them to multiply at a tremendous rate. Even though they appear clean, these cloths contaminate every surface they touch.

When treated with SANITIZING DUSTCHEK, these same cloths become bacteriostatic. This is demonstrated by the Agar Cup Test against the FDA S. Aureus, the antibiotic resistant S. Aureus 42 B/52/81, the corynebacterium diphtherae and other organisms.

SANITIZING DUSTCHEK permits *controlled impregnation* in bulk with ordinary hospital laundry equipment. It is a concentrated water soluble emulsion, easy and economical to use. For further information, ask your Franklin Research salesman or write direct to the company.

Discuss your dusting problems with us in Booth 103 at the Hospital Merchandise Mart at the Coliseum.

FRANKLIN RESEARCH
5134 LANCASTER AVE. / PHILADELPHIA 31, PA.
Branch Offices in Principal Cities

VERSATILE FURACIN

effective by intrapleural instillation[1]

the situation: Four-month-old infant with staphylococcal pneumonia and empyema resistant to most antibiotics was allergic to antibiotic chosen after sensitivity tests. Thoracentesis produced 30-40 cc. of creamy, purulent fluid. Organism was Staphylococcus aureus, coagulase positive.

then Furacin was instilled: 0.2% Solution was diluted equally with physiologic saline and 10 cc. of mixture instilled twice daily into pleural space, with suction catheter clamped off for 1 hour. Fluid almost immediately became thinner and less viscous. Twenty-four hours later infant was less irritable, voluntarily started taking food. Instillations stopped. FURADANTIN® Oral Suspension prescribed. Recovery uneventful.

1. Perkins, J. L.: Kansas State M. J. (to be published).

FURACIN®

brand of nitrofurazone

FURACIN has been in clinical use for more than 13 years. Today it is the most widely prescribed single topical antibacterial agent. Like other nitrofurans, FURACIN remains effective, even in pus, sera or exudates, against pathogens which have developed—or are prone to develop—resistance to antibiotics.

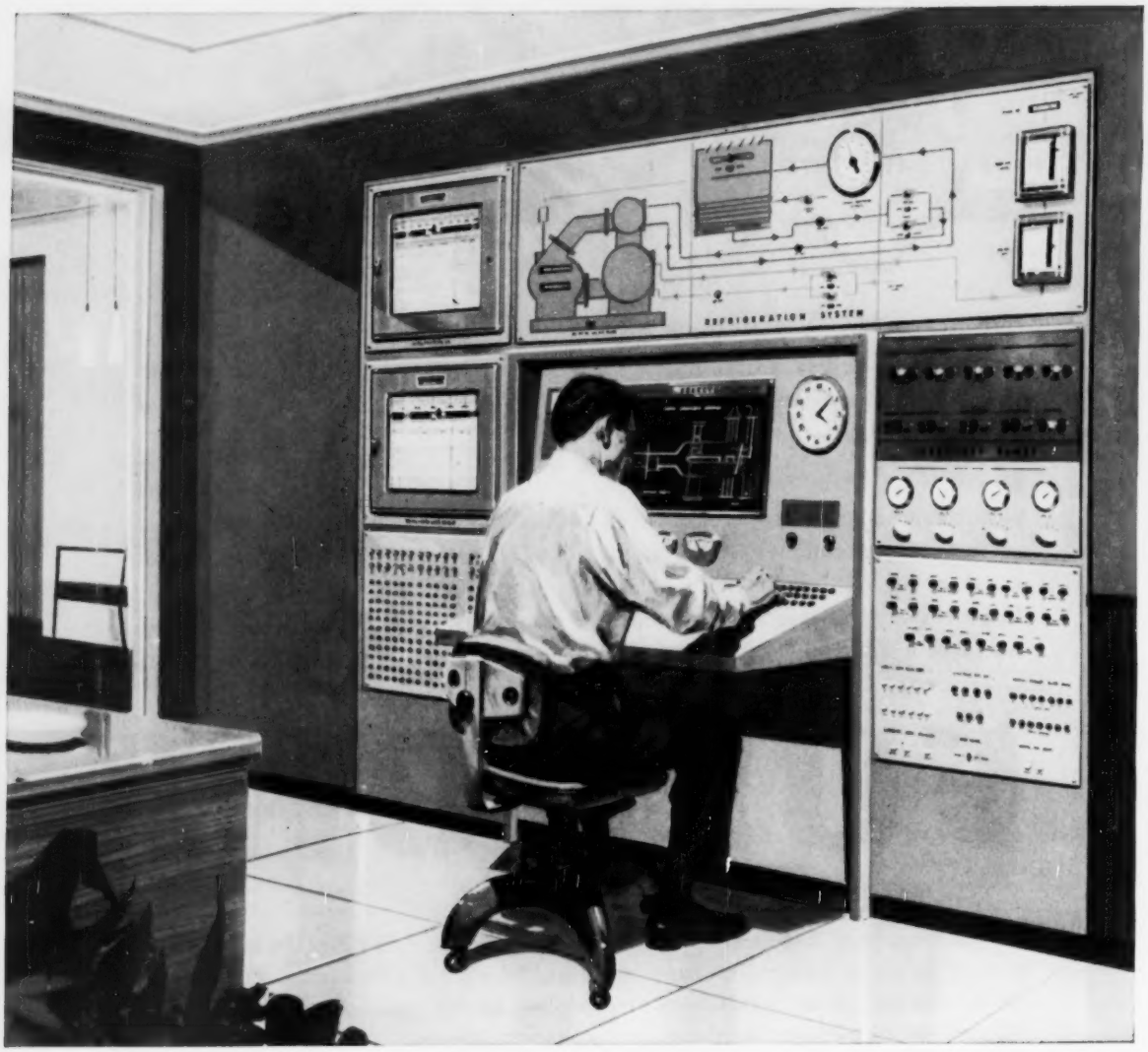
FURACIN, in a water-miscible base of polyethylene glycols, is available in a number of dosage forms. Included are Soluble Dressing, Soluble Powder, Solution and Cream. Also in Vaginal Suppositories, Inserts, and in special formulations for eye, ear and nose.

NITROFURANS—a unique class of antimicrobials—neither antibiotics nor sulfonamides

EATON LABORATORIES, NORWICH, NEW YORK

Honeywell Coordinated

. . . an answer in 3 parts—to 3 basic problems in hospital efficiency and patient satisfaction



For centralized control of all temperature functions and operations—Honeywell's new Selectographic Supervisory DataCenter*

Now a building engineer can "see" up to 50 separate fan system diagrams and floor plans, read and adjust critical temperatures throughout your hospital . . . all at one centrally located console. He can quickly read and adjust temperatures in public areas such as halls, cafeteria, waiting rooms, lobby. He can start and stop heating and cooling equipment as required. Power, steam and chilled water consumption and cost can be recorded and computed; adjustments made quickly and accurately. The result is increased efficiency and performance of heating and cooling equipment plus reduction in the size of your maintenance staff.

Temperature Control

For patient comfort—Honeywell's Bedside Pneumatic Thermostats

These individual room thermostats provide maximum patient comfort and give your nurses more time to devote to professional nursing. Patients are able to adjust room temperatures to suit themselves without bothering busy nurses. Nurses are freed from opening and closing windows, filling hot water bottles, adjusting heating and cooling equipment, carrying blankets and many other chambermaid chores that occupy their time.

For centralized control of special areas—Honeywell Hospital-Master*

From one small control panel located at the nurses station on special floors the nurse can control temperatures in delivery rooms, surgery rooms, mental detention wards, and other areas where the occupants are either too busy or incapable of making temperature adjustments. Surgeons can now have the temperatures they like best in these areas, with temperatures quickly and efficiently changed to meet special circumstances.

Honeywell has the complete answer to your hospital's temperature control needs

In the Selectographic Supervisory DataCenter, Hospital-Master, Bedside Pneumatic Thermostats—or a combination of all these features, Honeywell's experience in the hospital field gives you these benefits: greater operating efficiency at lower cost . . . longer equipment life . . . operational savings that liquidate cost . . . and above all, a more efficient hospital staff and happier, more comfortable patients. Get complete information by calling your local Honeywell office. Or write Minneapolis-Honeywell, Dept. HO-8-27, Minneapolis 8, Minnesota.

Honeywell

First in Control

FOR YOUR PROTECTION

–in plastic as in glass

DEKNATEL TRANSPARENT PLASTIC PAK IS STORED IN COLORED SOLUTION

"... it is desirable to color the solution with a dye so that if the solution is aspirated into an ampoule, the discoloration will signal the fact that the contents are unsuitable for use."*

All Deknatel Plastic Paks are stored in formaldehyde with fluorescein dye added—the direct visual assurance of sterility upon which you have relied with glass tubes.

*Carl W. Walter, M.D., "Aseptic Treatment of Wounds" (New York: The Macmillan Company, 1954), P. 172

For samples of Readi-Cut Silk, Surgical Gut, Needled Silk and Gut in the Deknatel Plastic Pak, write—

J. A. DEKNATEL & SON INC.

96-33 222 STREET, QUEENS VILLAGE 29, NEW YORK

these rigid specifications are

BASIC to BARDEX

for *perfected* performance

TIP Not too short, not too long. Just right to ease insertion, not so long as to irritate bladder.

EYE Properly placed and sized in strong, reinforced tip. Design that assures entirely proper drainage.

RIBS To assure even distention of balloon—extra reinforcing rubber that also strengthens balloon. Tip held in proper position, too.

SHAFT Smooth, round, with large lumen. Still another factor that means easy insertion, maximum drainage, and a minimum of patient discomfort.

PLUG Easily punctured, self-sealing and always secure. Of specially compounded crepe latex, with long ridged side-walls, and cemented in inflation tube.

SIZE Permanently shown by color patch. Identity not lost in autoclaving.

There is a difference . . . and just such "basics" as these tell you why "the standard of excellence" has long been BARDEX.

Of vital importance to hospital and patient is your specification of BARDEX, for dependable catheter performance.

BARDEX® FOLEY CATHETERS

More widely used throughout the world . . . than all other brands combined.

583 **C. R. BARD, INC.** SUMMIT, N.J.

STERILE in the durable, **easy-to-open package** that affords guaranteed protection . . .

ready for instant use without processing or autoclaving

ONE CALL DOES IT ALL... *fast*

...x-tra value x-ray supplies

there's no delay the G. E. way

Dealing with General Electric is like owning your own complete warehouse of x-ray supplies. You get fast action on every order from any of 68 strategically located factory-operated offices.

No need for "scatter-buying" from several different sources. Get everything you need by "shopping" the complete selection of products listed in the G-E X-Ray Supply and Accessory Catalog.

Call your G-E x-ray representative *(he's listed in the yellow pages of your phone book)*. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin for Pub. L-86

EXAMPLE:

Continuous cash savings—G-E SUPERMIX® film processing chemicals are today's *lowest-priced* quality solutions. Convenience packaged, too, in tough, knock-about plastic containers — developer, fixer, refresher and fixer-neutralizer in graduated polyethylene bottles that mix a gallon. (And so *lightweight* they're a joy to handle.)

Progress Is Our Most Important Product

GENERAL ELECTRIC

introducing the authors

G. O. Lindgren, administrator of Trinity Lutheran Hospital, Kansas City, Mo., reports how the hospital renovated its facilities without disruption of services or loss of income (p. 54). Mr. Lindgren joined the hospital staff in 1951 at which time the hospital embarked on a $2 million development program.

MR. LINDGREN

Mr. Lindgren brings to the hospital administrative field many years of experience in the teaching and business management fields. After receiving his B.A. degree in education from the University of North Dakota, Mr. Lindgren served as superintendent of schools in a number of districts in North Dakota until 1936. During this period he completed requirements for a master's degree in education administration at the University of North Dakota and began work on his doctorate at the University of Minnesota.

During the next 15 years he served as a college and university business manager.

Since his entrance into the hospital field eight years ago, Mr. Lindgren has served a number of regional and state hospital and Blue Cross groups. He is a trustee and past president of the Mid-West Hospital Association, a director of the Kansas City Area Hospital Association and a trustee of Group Hospital Service, Inc., Kansas City, Mo.

Mr. Lindgren is a member of the American College of Hospital Administrators, the National Education Association and Phi Delta Kappa, honorary education fraternity.

Mr. and Mrs. Lindgren's son, Carlton, is administrator of Lutheran Hospital, Hot Springs, S. Dak.

Thomas McKeown, M.D., calls for a multiple-building hospital community in whch all patients can be treated according to their needs rather than separate hospitals for treatment of different categories of illnesses (p. 40). Doctor McKeown is professor and head of the department of social medicine at the medical school, University of Birmingham, Edgbaston, Birmingham, England.

Doctor McKeown also serves as a member of the Birmingham Regional Hospital Board and holds membership on the board of governors of Birmingham United (Teaching) Hospitals. Since 1950 he has served as editor of the *British Journal of Preventive and Social Medicine.*

According to the *Medical Register of British Physicians,* Doctor McKeown received M.B. and B.S. degrees from the University of London in 1942. Five years later he received an M.D. degree from the University of Birmingham.

He earned a Ph.D. at McGill University (National Research Council scholar) and a doctorate in philosophy at Oxford (Rhodes scholar).

Doctor McKeown is a fellow of the Royal College of Physicians.

Steve J. Soltis reports that Beckley (W.Va.) Memorial Hospital has found that disposable syringes and needles save dollars and staff time and insure greater sanitation than the reusable variety in his article on p. 72. Mr. Soltis is administrator of Beckley Memorial, one of the group of 10 hospitals comprising the Miners Memorial Hospital Association.

MR. SOLTIS

Prior to the hospital's completion in 1956, Mr. Soltis served with the Miners association office in Washington for three years. He formerly served as assistant administrator of Memorial Center for Cancer and Allied Diseases in New York City.

Mr. Soltis is a member of the American College of Hospital Administrators.

SAVE STEPS FOR BUSY STAFFERS ...KEEP A STANDBY® NEARBY

An extra Standby Baumanometer® on each patient floor can save much time and effort for busy nursing personnel. These self-contained, easily portable units can be stationed right at bedside when frequent bloodpressure readings are required, as in the care of the post-op patient. This convenient arrangement eliminates hunting and retrieving borrowed instruments.

The Standby Model is particularly well-suited to the demands of hospital service. It is durably constructed for long, hard use; it is easy to read from any position. And it carries the most generous guarantee of any sphygmomanometer available.

Your local Baumanometer Dealer will be happy to show you the Standby Model...and the entire Baumanometer line designed for practical, economical standardization. Call him.

Baumanometer
BLOODPRESSURE STANDARD THE WORLD OVER

W. A. BAUM CO., INC.
Copiague, Long Island, New York

IVORY SOAP...
Mild enough for a baby's skin!

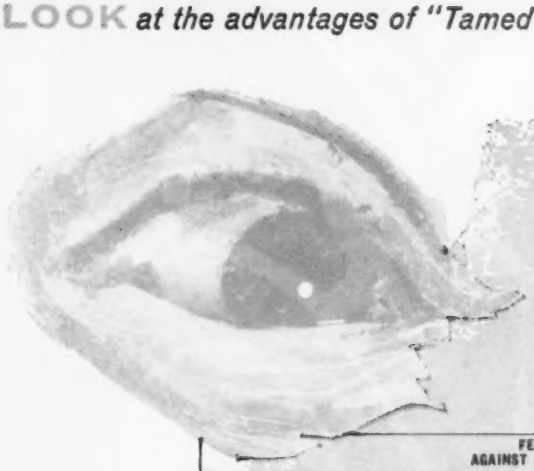
—one reason why Ivory is by far the leading soap in hospitals everywhere!

There are 233 separate tests for mildness and purity that Ivory must pass before it is given the supreme test—baby's tender skin. Of course, Ivory has passed this test, too—and with highest marks—for more than 80 years. More doctors recommend Ivory than any other soap for both old and young patients. And today, Ivory has become the leading soap in hospitals everywhere. Its gentle lather cleanses thoroughly, yet is mild and refreshing even to the most delicate skin. Give Ivory a trial in your institution. It will quickly win your confidence, too!

IVORY
Soap

99⁴⁴/₁₀₀% pure® . . . it floats

LOOK *at the advantages of "Tamed Iodine"®*



WESCODYNE®

FEATURES OF TAMED IODINE AGAINST OTHER TYPES OF DISINFECTANTS

	Chlorines	Quats	Creosols	Pines	Synthetic Phenols	WESCODYNE
Microbial Activity	Very short	Variable	Intermediate	Poor to variable.	Intermediate	High
Stability	No	Yes	Yes	Yes	Yes	Yes
Cost in Use	Low, but require frequent application.	High	High, too much needed.	Low, but require frequent application.	Moderate to low.	Very low.
Odor	Heavy and penetrating.	None	Heavy	Heavy and lingering.	Some are heavy, others linger.	Very light and non-lingering.
Cleaning Ability	None, cause bleaching.	Poor, inactivated by soaps.	Good	Good	Good	Good
Microbiology	Selective germicide. Will not destroy a wide range of organisms.	Selective germicide. Will not destroy a wide range of organisms.	Selective germicide. Will not destroy a wide range of organisms.	Selective germicide. Will not destroy a wide range of organisms.	Selective germicide. Will not destroy a wide range of organisms.	A nonselective germicide. Kills bacteria, virus, molds, fungi, yeast, spores, etc.
Affected by Hard Water	No	Yes	Yes	Yes	In some cases.	No
Indicator of Bacterial Efficiency	None	None	None	None	None	Color
Effect on skin, full strength	Irritants	Sensitizers	Irritants	Non-irritating	Irritants	Non-irritating
Toxicity	Yes	Variable	Yes	No	Yes	No

EXTRAORDINARY GERMICIDE

WESCODYNE is the *first "Tamed Iodine" hospital germicide.* It offers extraordinary advantages. Nonselective biocidal activity. A cleansing detergent action. Extremely low cost. And more, as indicated in the above comparison.

Important, too, tests on common pathogens show that WESCODYNE offers greater germicidal capacity for the control of cross infection.

WESCODYNE is the single germicide suitable for all hospital cleaning and disinfecting procedures. Its labor-saving detergent action removes soil and dust as germs are destroyed. This simplifies procedures, including those for the decontamination of surfaces that harbor "Staph" and other organisms.

WESCODYNE costs less than 2¢ a gallon at its general-purpose use dilution. It has an unmatched history of scientific evaluation and success. We'd be glad to send full information, a sample and recommended O.R., housekeeping and nursing procedures. Just call your nearby West office. Or send the coupon below to our Long Island City headquarters, Dept. 26.

☐ Send a WESCODYNE sample and full information.

☐ Have a representative phone for an appointment.

Name_____

Position_____

PROGRAMS AND SPECIALTIES
FOR PROTECTIVE SANITATION
AND PREVENTIVE MAINTENANCE

WEST DISINFECTING DIVISION

WEST CHEMICAL PRODUCTS INC.
42-16 West Street, Long Island City 1, New York
Branches in principal cities
CANADA: 5621-23 Casgrain Avenue, Montreal

antibiotic **resistant STAPHYLOCOCCI** are killed by

ZEPHIRAN® in seconds

USE ZEPHIRAN TO HELP CURB THE CURRENT MENACE TO HOSPITAL HEALTH

Preoperative preparation • Scrub-up • Surgical dressings • Wound irrigation • Sterile storage of instruments • Furniture, wall, and general sickroom disinfection • Laundry

Zephiran chloride, brand of benzalkonium chloride refined (to ensure quality). **WINTHROP LABORATORIES, NEW YORK 18, N. Y.**

1335M

HEARINGS ON HOSPITAL COSTS OPEN IN MARYLAND—A special committee appointed by the Maryland legislature began a series of hearings July 28. The hearings, a phase of a legislative study, were expected to deal with (1) quality of care; (2) method of Blue Cross reimbursements to hospitals, and (3) extravagance and overuse as causes of rising rates.

Opening of the legislative committee's public probe into hospital-Blue Cross affairs came soon after an earlier hearing, that before the state insurance commissioner, on the Blue Cross plan's petition for a rate increase. At that hearing, the commissioner brought clamor from parties opposing the increase by ruling that (1) he would not allow the hearing to grow into a broad investigation of hospital service and costs, and (2) he would not permit oral examination of witnesses. Details p. 100.

The special committee early this month heard the testimony of Dr. Russell A. Nelson, president-elect of the American Hospital Association and director of Johns Hopkins Hospital, Baltimore. Dr. Nelson appeared on August 4, at the second hearing in a series, and was followed by John A. Schaffer, president-elect of Maryland-District of Columbia-Delaware Hospital Association.

The testimony at the August 4 hearing emphasized the active role of trustees in hospitals; medical staff responsibilities; effects of medical progress on hospital costs; the causes of rising personnel costs and their impact on total hospital expense, as well as the continuing efforts of hospitals to achieve maximum efficiency.

Committee questioning of witnesses focused on control of misuse of Blue Cross by hospitals, especially with regard to reviews of cases by medical staff committees, and on hospital accounting procedures. (A full account of the hearings will appear in the September 1 issue of this Journal.)

OSTEOPATHS VOTE FOR FREEDOM FROM AMA SUPERVISION—The American Osteopathic Association voted at the last annual convention to maintain an independent educational system. This action answered an earlier resolution by the American Medical Association House of Delegates that suggested, in effect, supervision of osteopathic colleges by the AMA. "This is too great a price to pay for acceptance," said AOA past president Dr. George W. Northup in referring to the AMA resolution.

Other convention speakers also pointed up D.O.'s resistance to "amalgamation or merger with the AMA." One delegate commented on the "wholesome competition" between osteopaths and organized medicine.

- Illinois legislation recently enacted was announced at the convention. The new state statute will extend the right to practice complete medicine and surgery to all osteopaths who complete a refresher course.
- In Missouri, a new Medical Practice Act provides for a single licensing board for osteopaths and M.D.'s. Single boards now examine candidates for healing arts licensure in 19 states. Details p. 98.

DISPUTE OVER DRUG 'SUBSTITUTION' AWAITS FURTHER ACTION—Another court hearing has been scheduled on the year-long controversy between Philadelphia's Hahnemann Hospital, a manufacturer of pharmaceuticals, and the Pennsylvania State Board of Pharmacy over alleged "substitution" of medication.

As a result of action on the part of Schering Corporation, the chief pharmacist of the hospital received notification last June from the State Board of Pharmacy that his license would be suspended. The hospital at that time was notified that it would be denied renewal of its pharmacy license if the chief pharmacist remained as manager of the hospital pharmacy. Details p. 97.

REPORT FROM WASHINGTON—Senate subcommittee hearings kept high the interest in the problems of the aged and aging. The subcommittee concerned itself with seven major subjects, ranging from the housing needs of the elderly to the ways of making the life of the retired productive and meaningful.

Other hearings, in a number of major cities, were scheduled to follow. In the meantime, the Department of Health, Education, and Welfare was working on a plan for a government-run system that would provide health care for the aged. Details p. 91.

- House hearings began on a bill that would establish health insurance for federal employees. The measure was earlier approved by the Senate. The American Hospital Association testified before the House committee in support of the measure. Details p. 91.
- Another legislative item already approved by the Senate and awaiting House decision was a resolution authorizing $50 million a year for international health research. Details p. 92.
- HEW Secretary Arthur S. Flemming has announced that improvements in the method used to dispose of federal surplus property were being studied by the agencies involved. The plan would make it easier for hospitals to obtain such property and would speed up the process. Details p. 93.

VA BROADENS PHARMACIST TRAINING PROGRAM—New training opportunities in hospital pharmacy will be offered by Veterans Administration hospitals during the 1959 fiscal year.

The VA announced that a new program of pharmacy internships will begin at the Manhattan, N.Y., Hines, Ill., and Oakland, Calif., VA hospitals. The one-year internships will allow recent pharmacy graduates of recognized schools to receive specialized training in hospital pharmacy. They will, at the same time, provide the experience required for state pharmacists' licenses.

The VA program of hospital pharmacy residencies will also be continued, and it will be extended to another, eighth hospital, the Oakland VA hospital, in cooperation with the University of California and other area hospitals.

The other seven VA hospitals offering hospital pharmacy residencies are at St. Louis, Mo., Los Angeles, Iowa City, Indianapolis, Pittsburgh, Hines, Ill., and Fargo, N. D. The residencies are conducted in cooperation with nearby universities, and most of them last 22 months.

RATES INCREASED FOR 5TH PENNSYLVANIA PLAN—Another Pennsylvania Blue Cross plan received a rate increase last month. An average raise of 34.7 per cent was approved for Hospital Service Association of Northeastern Pennsylvania (Wilkes-Barre-Scranton area) by Insurance Commissioner Francis R. Smith, effective August 1. Four other Pennsylvania Blue Cross plans had received rate increases from commissioner Smith earlier in July.

FLORIDA BLUE CROSS APPLIES FOR RATE BOOST—Blue Cross of Florida, Inc. applied to the state insurance department last month for a rate increase averaging 20 per cent. H.A. Schroder, executive director of the plan, pointed out that this was the first time since 1956 that Blue Cross of Florida has petitioned for a rate boost. Insurance Commissioner Edwin Larson conducted public hearings on the plan's proposal on July 17, but postponed his ruling until a later date.

HOSPITALS AID ACCIDENT STUDY IN PENNSYLVANIA—Hospitals in Pennsylvania are aiding the state Department of Health in a two-year accident injury study, it was reported by *The Bulletin*, a publication of the Hospital Association of Pennsylvania.

Under the program, a network of hospitals will furnish the health department specific information on injuries suffered in nontraffic accidents. The department suggested that emergency room nurses and medical record librarians would be the logical personnel to handle report forms.

The Pennsylvania Department of Health will tabulate and analyze the reports for a three-fold purpose: to guide the department's accident prevention program plans, to serve as an evaluation tool for safety projects, and to use the data in research into accident causes.

WISCONSIN HOSPITAL-SPECIALIST CONTROVERSY ENDS IN LEGISLATION—Months of negotiations between the hospital and medical societies in Wisconsin as to the specialist hiring practices ended in a statute amendment which declared that contracts between hospitals and specialists are lawful. The statute further stipulated that although hospitals may bill for the services of specialists, such services must be shown in the departmental charges and the physician must be indicated by name. Details p. 102.

STOP
SEE

& PRICE

the new line of VIM standard & disposable syringes & needles—contact your Surgical Products Divison representative, or write direct.

VIM®

CYANAMID
AMERICAN CYANAMID COMPANY
SURGICAL PRODUCTS DIVISION
30 ROCKEFELLER PLAZA
NEW YORK, N.Y.
Sales Office: Danbury, Connecticut

PRODUCERS OF DAVIS & GECK SUTURES AND VIM HYPODERMIC SYRINGES AND NEEDLES

world's most advanced hospital furniture

WOODRIDGE...by Royal®

Designed to make patient rooms cheerful, restful, relaxing . . . WOODRIDGE, by *Royal* combines the warmth of wood with sturdy steel inner construction for beauty, efficiency and durability. Attractive Finish Birch or American Walnut plywood panels and virtually indestructible Royaloid tops are individually replaceable for simplified maintenance. Drawers have nylon runners and glides, all-metal interiors . . . never warp or stick. Responsive *Royal* Hi-Lo Bed raises from 18" to 27" in seconds. Elevates at either end or both. Trendelenburg position in 10 seconds, Fowler in 25 seconds.

Write for information and literature to:

ROYAL METAL MANUFACTURING COMPANY
One Park Avenue, New York 16, Dept. 7-H

Please send me descriptive literature and full information on Royal Woodridge patient room furniture.

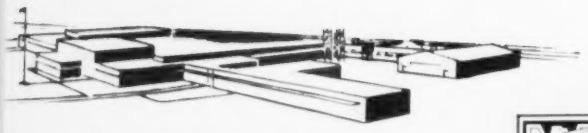
Name _____

Hospital _____

Address _____

City _____ Zone _____ State _____

Ear to the ground.....



At AMSCO's Erie, Pennsylvania Research Division, analysis, investigation and evaluation are based upon world-wide knowledge of hospital procedures and problems.

·AMSCO·
LABORATORIES
ERIE, PENNSYLVANIA
DIVISION OF AMERICAN STERILIZER COMPANY

AMERICAN
STERILIZER
COMPANY OF CANADA, LIMITED
BRAMPTON — ONTARIO

WORLD'S LARGEST DESIGNER AND MANUFACTURER OF HOSPITALS, J.A.H.A.

250,000 TIMES THROUGHOUT THE WORLD!

THE 250,000th unit of major technical equipment shipped from American Sterilizer will be installed at the new 25 million dollar Hadassah-Hebrew University Medical Center in Jerusalem, Israel. It is one of five M. E. Bulk Sterilizers included in Amsco's initial equipment list for this most important new Medical Center in the Near East.

It might have been a Surgical Operating Table, a Sonic Energy Cleaner or a complete Solutions Room. Its destination could have been Reykjavik, Iceland; Johannesburg, South Africa . . . or Topeka, Kansas. The "what" and "where" are relatively unimportant.

What IS significant is that this installation, like the thousands which preceded it, marks still another "ear to the ground" for American Sterilizer Research and Development.

In more than a hundred countries of the world, AMSCO techniques and equipment are advancing patient welfare, increasing hospital efficiencies and **communicating to our Laboratories the problems, ideas and data which are the raw materials of applied research.**

By virtue of these global listening posts, AMSCO Research Scientists and Professional Consultants actually draw upon "a world of experience" in their ceaseless progress toward better techniques for hospitals everywhere.

That's why there have been so many distinguished "firsts" in American's achievements on behalf of hospitals and the biological sciences . . . and why there are always more in process.

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

Remember this world of experience when you have a problem relating to hospital techniques or biological research. Remember, too, that we *like* to be helpful.

·AMSCO·
DE MEXICO·S.A.
MEXICO·D.F.
DR. GARCIAC EGO. 170 · APDO. 7320

·AMSCO·
·EUROP NV
ROTTERDAM·NETHERLANDS

STERILIZERS, SURGICAL TABLES, LIGHTS AND RELATED HOSPITAL EQUIPMENT

In beautiful Naples, too, you'll find Pentothal

Naples, rich in artistic heritage, enjoys also all the advantages of modern medical science. A reflection of this is the growing use of Pentothal by clinicians here. Its notable record of safety, its versatility, effectiveness and its dependability are some of the reasons why Pentothal warrants such wide-spread trust. With more than 3000 published reports, Pentothal is unmistakably the world's most widely used and studied intravenous anesthetic. Abbott

PENTOTHAL® Sodium

(Thiopental Sodium for Injection, Abbott)

the intravenous anesthetic used in more than 75 countries of the world

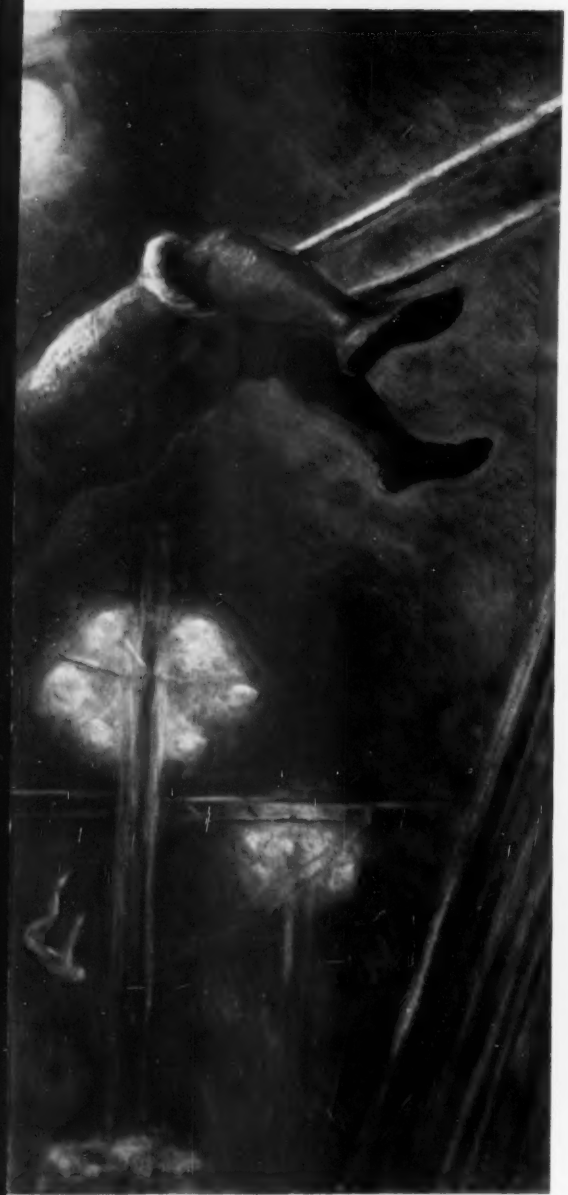
Free. A reprint suitable for framing of Frede Vidar's painting of Naples (opposite page) is yours for the asking. Write: Professional Services, Abbott Laboratories, North Chicago, Illinois.

RELIABILITY I

PASSING LEAP by John Steuart Curry, this month's symbol of reliability in action. Available in 25 x 23 size for framing. Write Professional Services, Abbott Laboratories, North Chicago, Illinois.

vidar

N ACTION



Beneath that Abbott bottle cap
you'll find more of value
than the parenteral
solution alone.
Also traveling with that bottle
is a lifetime's reputation.
With every bottle,
Abbott puts that hard-won
reputation at stake.
Small wonder we take
such extreme care.

ABBOTT PARENTERALS
SOLUTIONS AND EQUIPMENT

© 1993 ABBOTT LABORATORIES 8070OR

accreditation problems

KENNETH B. BABCOCK, M.D.

- trustees' attendance at meetings and accreditation
- overlapping and sharing of information from JCAH surveys and AMA inspections
- attendance at medical staff meetings
- identification of the newborn

In order that a hospital become accredited, is it mandatory that the trustees attend 75 per cent of the board meetings?

No. The Commissioners of the Joint Commission have never mentioned any attendance requirements for trusees in their Standards. It is presumed that a board of trustees would review the attendance of its members and drop those who did not regularly attend and who were not interested in the hospital.

Accreditation of a hospital is based on compliance with very general principles and standards, and never on arbitrary quantitative measures. Accreditation tries to help and show a way; its function is not punitive.

* * *

1. Is there an overlapping of the surveys and inspections by the Joint Commission and the Council on Medical Education and Hospitals of the American Medical Association?

2. Do the two groups share their information?

3. Are the results of one inspection relayed to the other?

1. Yes, there can't help but be some overlapping, although it is not great and has not proved bothersome or controversial.

2. The two groups share their information in principle. Consultations between members of the respective staffs are held when necessary. Rapport is excellent.

3. Each staff has a knowledge of the final action taken by the other, but no specific information is ever relayed back and forth, i.e., work sheets or the actual reports.

* * *

We have seven doctors on our medical staff. They meet monthly and there is close to 100 per cent attendance at staff meetings. Can we skip the last two or three meetings of the year if each doctor has met the required 50 per cent attendance requirement?

No. Such a query is a sad reflection on the medical staff. Do doctors attend meetings to pass a mandatory attendance requirement or to try and improve the quality of care in their hospital? The Commission hopes it is the latter motivation.

* * *

At our hospital the sole means of identification of babies is their photograph on the chart. Is this sufficient?

No. The Commission recommends that in addition to a photograph, a hospital must use at least two other means of identification and of different types. One type of identification may be by means of a wristlet, dogtag or necklace while the second may be by means of fingerprint, footprint or palmprint. As to the latter, the Joint Commission has no preference as long as it is done well.

This material has been prepared by the Joint Commission on Accreditation of Hospitals, Dr. Kenneth B. Babcock, director. Questions should be sent to the Commission, 200 E. Ohio St., Chicago 11, Ill., or to HOSPITALS, J.A.H.A., for referral to Dr. Babcock and his staff.

why are more and more hospital washrooms going

"UNDER TURN-TOWL CONTROL"?

Because they are finding out that towel consumption goes up as towel quality goes down!

No matter how good the quality, towels will be wasted unless the dispensing of them is controlled.

MOSINEE TURN-TOWLS have proved in hospitals all over the country that they will reduce consumption *40% to 50%*. Since the quality is excellent, it means a fine washroom service can be had at a low service cost.

Write for the name of nearest distributor

MOSINEE Sulphate Towels
BAY WEST PAPER CO.
1120 West Mason Street
GREEN BAY • WISCONSIN
Subsidiary of Mosinee Paper Mills Co.

IN A RECENT QUESTIONNAIRE:

335 OUT OF 350 REPORTING DOCTORS SAID THEY RECOMMENDED SUPP-HOSE TO THEIR PATIENTS!

Recently we wrote to approximately 1100 doctors. We enclosed a letter, questionnaire and an offer of a sample pair of Supp-hose. Of the 350 doctors responding, 335 of them indicated they were recommending Supp-hose to their patients. This is just one phase of the growing popularity of Supp-hose. From every part of the country comes news of more and more women who find that Supp-hose gives them the fashionable look they want . . . and at the same time eases tired legs!

MANY WOMEN COMPLAIN ABOUT TIRED LEGS

As you know, expectant mothers, housewives, and working women all complain about discomfort of the extremities. Where heavy surgical stockings are not prescribed, Supp-hose is excellent for gentle support all day long. And remember: Supp-hose contains no rubber. Every stitch is fine nylon with a special twist that provides an elastic quality.

A VERY ECONOMICAL STOCKING!

Patented Supp-hose costs a woman just one-third what she usually pays for heavier surgical stockings. And wear tests indicate Supp-hose should give many times the wear of ordinary nylons, Supp-hose is available in proportioned sizes in beige, natural and white. At drug and department stores. **$4.95 PAIR**

Supp-hose®

the first sheer all-nylon stocking that eases tired legs

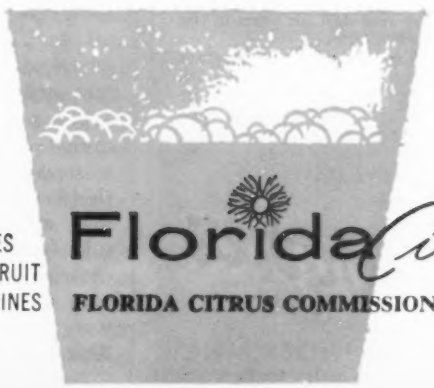
Kayser-Roth Hosiery Company, Inc. Division of Kayser-Roth Corporation, 200 Madison Ave., N. Y. 16, N. Y. • U. S. Pat. #2,841,971

there's no juice like citrus *juice*

As a high-potency source of vitamin C, citrus juice—fresh, frozen, or canned—is unmatched for convenience and economy. The table below shows amounts† of other fruit juices required to supply the 100 mg.* of vitamin C in one glass (7-9 fl. oz.) of citrus juice.

citrus	1 glass
apple	50 glasses
grape	9 glasses
pineapple	3-4 glasses
prune	50 glasses

†Data calculated from: Watt, B. K. et al., U.S. Dept. Agric. Handbook No. 8, 1950; and Burger, M. et al. Agr. & Food Chem. 4:418, 1956.



*This is the peak of the Recommended Daily Allowances for adolescence or pregnancy; 150 mg. during lactation; 70-75 mg. for normal adults.

ORANGES
GRAPEFRUIT
TANGERINES

Florida *Citrus*

FLORIDA CITRUS COMMISSION • Lakeland, Florida

TWO members of the professional staff at Greenwich (Conn.) Hospital display oil paintings they entered in the hospital's art show.

PHARMACEUTICAL assistant at the Greenwich (Conn.) Hospital explains one of his entries to the hospital's medical illustrator. Seal at left is his work, too.

Hospital artists' show is an annual event

The practice of medicine is an art and not an exact science. Is it any wonder then that a physician was responsible for starting an art show at the Greenwich (Conn.) Hospital? It was Frank A. Read, M.D., director, department of surgery, who first broached the idea to the hospital administration, reports Albert F. Varner Jr., the hospital's administrative assistant.

Nurse's aide at Greenwich Hospital admires one of the ceramic works entered in this year's art exhibit in the hospital lobby.

In 1958 Dr. Read served as chairman of the Fairfield County (Conn.) Physicians' Art Association of the American Medical Association. The national medical organization requested local area chairmen to encourage art exhibits within their own medical societies. Doctor Read carried the idea a step further and suggested an art exhibit by hospital personnel. The suggestion was carried out and the exhibit was so successful that it was repeated in May 1959.

Neither of the exhibits was planned with the idea of having prizes or developing competition among the entrants; they were designed to create an interest in art and to provide an opportunity for hospital personnel to display their work.

The hospital administration agreed to make the lobby at the front entrance available for an exhibit for three weeks during May, including National Hospital Week. Doctor Read accepted the chairmanship of a local hospital committee to organize and plan the display. Serving on the committee were another member of the medical staff, a faculty member of the school of nursing, and the hospital's medical illustrator.

The committee issued a general invitation to all hospital personnel to send in art work for the show. In 1958 more than 100 oil paintings, water colors, ceramic works, salon-type photographs, charcoal drawings, needlepoint and sculpture works, and pencil drawings were submitted for the exhibit. This year 100 entries were sent in.

Based on plans drawn by the

Mop hospital floors quicker with Geerpres mopping outfits

"FLOOR-KING" Twin Tank Mopping Outfit for mops to 36 oz.

Keeping floors clean is a constant battle that can't be eliminated. But it can be made easier. You'll get the job done in a hurry when you use a Geerpres mopping outfit.

Easy-working, powerful interlocking gearing wrings mops as dry as you please without twisting or tearing. Best of all, no splashing on clean floors or clothing.

Geerpres buckets roll at a touch on quiet, rubber wheeled ball bearing casters. Electroplated wringer and rugged, hot dip galvanized buckets stop rust—last for years in the hardest service.

Keep it clean. Get a Geerpres mopping outfit today. Both single and twin-tank outfits available in three sizes plus other mopping accessories. See your jobber or write for complete catalog.

Geerpres

WRINGER, INC.

P.O. BOX 658, MUSKEGON, MICH.

medical illustrator, the hospital's carpenter shop made the display boards. They consisted of four, 4 by 16-foot peg board panels. Each panel was notched in the center and fitted together egg-crate style. The result was sixteen, 4 by 8-foot display panels for displaying the various entries. Supporting legs, fitted between the panels, lifted the peg boards three-and one-half feet from the floor.

Among those who exhibited their work were doctors, nurses, technicians, an accounting clerk, admitting officer, pharmaceutical assistant, member of the maintenance department, housekeeping maids, nurses' aides and volunteers of the hospital.

The exhibit drew hundreds of visitors—the general public as well as hospital personnel. Many patients stopped to see the exhibit at discharge time and those who were able asked to be taken to the lobby by wheel chair to view the display.

The local press took news photographs of some of the artists with their works (see photos on facing page). The resulting publicity attracted even more visitors and created an even more favorable public reaction.

Almost everyone who saw the exhibit—both last year and this year—expressed surprise and great interest in seeing the display of talent by hospital employees. One doctor said: "It's interesting to know the talents that others have and the art exhibit was an excellent means for them to show their works." A nurse summed up the value of the exhibit as follows: "The show brought out the warmth of the hospital and the people who work in it."

One nurse who entered her one and only painting on a "dare" had had only three months of art lessons through a once-a-week adult education course. The 1958 art exhibit at the hospital and particularly the enthustic response of those who saw her painting prompted her to enroll in another art class.

Hospital personnel are looking forward to next year's show; some who have not participated so far have gone one step further and said they plan to enter a painting or other artistic work.

Now, for the first time, a lamp mounted on a bedside cabinet *(by Hill-Rom)*

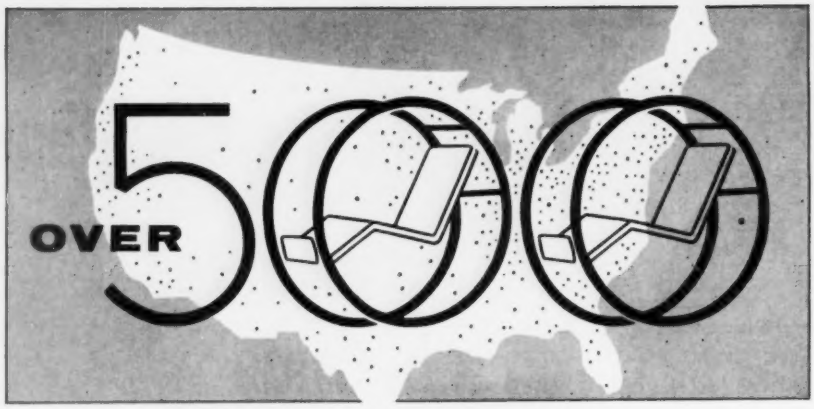
puts the light right where you need it

Here, for the first time, is a lamp placed where a hospital lamp should be placed—on the bedside cabinet within easy reach of the patient, yet out of the way of the nurse. This new Hill-Rom lamp is attached to the back side of the cabinet. It rolls on a track, so may be used on either side of the cabinet. It may also be moved entirely out of way when full access to the top of the cabinet is desired.

A parabola shade inside the outer shade permits spotting the light when intensive light is needed for examination. Inverting the shade gives indirect light. The shade is ventilated—will never become hot. A convenience outlet permits plugging in any electric appliance used at the bedside.

This lamp is completely approved by Underwriters' Laboratories, Inc. as safe for hospital use. Complete information on request.

HILL-ROM COMPANY, INC. • Batesville, Indiana



Stryker CircOlectric

Universal Hospital Beds already in use throughout the U. S.

ALABAMA
Univ. Hosp. & Hillman Clinic, Birmingham
Crippled Children's, Birmingham
Jackson Mem., Montgomery
Carraway Methodist, Birmingham
V. A. Hosp., Tuskegee

ARIZONA
Benson Hospital, Benson
Parkview Hospital, Yuma

ARKANSAS
St. Joseph's, Hot Springs
Washington C'ty., Fayetteville

CALIFORNIA
Herrick Mem., Berkeley
Ventura County Gen., Ventura
Stanford Convalt. Home, Palo Alto
Grossemont, La Mesa
Riverside Comm., Riverside
Huntington Mem., Pasadena
Kaiser Found., Fontana
Marin General, San Rafael
Sharp Memorial, San Diego
St. Joseph's, San Francisco
Orthopedic, Los Angeles
V. A. Hosp., San Francisco
Peninsula, Burlingame
Long Beach Osteo., Long Beach
St. Francis, Santa Barbara
San Gargonio Pass Mem., Banning
Tulare-Kings County, Springville
Hosp. of the Good Samar., Los Angeles
Westside, Los Angeles
Long Beach V. A. Hosp., Long Beach
St. Francis, San Francisco
Seaside Mem., Long Beach
California, Los Angeles
St. Francis, Lynwood
El Centro Com., El Centro

COLORADO
Fitzsimmons Army, Denver
Presbyterian, Denver
Loveland Mem., Loveland
Community, Boulder
St. Mary's Gorwin, Pueblo
V. A. Hosp., Denver

CONNECTICUT
Charlotte Hungerford, Torrington
Greenwich, Greenwich
Hosp. of Raphael, New Haven
Norwalk, Norwalk
Community Hosp., New London

FLORIDA
Hope Haven, Jacksonville
North Broward, Ft. Lauderdale
North Shore, Miami
Halifax District, Daytona Beach
Ft. Walton Beach, Ft. Walton Beach
Memorial, Sarasota
Duval Medical Center, Jacksonville
Jackson Mem., Miami
Tampa Gen., Tampa
Variety Children's, Miami
Monroe General, Key West
Amer. Leg. Hosp. for Crip. Chi., St. Petersburg
Florida A. M., Tallahasse

GEORGIA
Elberton Elbert City, Elberton
University Hosp., Augusta
V. A. Hosp., Dublin
Ga. Warm Springs Foun., Warm Springs

HAWAII
Queens Hospital, Honolulu

ILLINOIS
Oak Forest, Oak Forest
St. Mary's, Kankakee
Memorial Hosp., Carthage
U. of Chicago Clinic, Chicago
Wesley Mem., Chicago
Mercy, Chicago
Resurrection, Chicago
Evanston, Evanston
Rehab. Inst. of Chicago, Chicago
St. Luke's, Chicago
Community Gen., Sterling
Alton Mem., Alton
St. Joseph's, Joliet

INDIANA
Community, Indianapolis
Welborn Mem. Baptist, Evansville
St. Francis, Beech Grove
St. Margaret's, Hammond
Lafayette Home, Lafayette
Memorial, South Bend
Marks Nursing Home, Mango
Parkview Mem., Ft. Wayne
Methodist, Indianapolis

IOWA
Lutheran, Hampton
Methodist, Sioux City
Schutz Mem., Waterloo
Community, Grinnell
St. Joseph's, Keokuk
St. Vincent's, Sioux City

KANSAS
St. Rose, Great Bend
Epworth, Liberal
Asbury, Salina
St. Francis, Topeka
St. Elizabeth, Hutchinson
Trago County Hosp., Wakeeney

KENTUCKY
Owensboro Daviess, Owensboro
Red Cross Hosp., Louisville
Our Lady of Mercy, Owensboro
St. Luke's Hosp. of Campbell C'ty., Ft. Thomas
Rehab. Center Inc., Louisville
Children's, Louisville
Hardin County, Elizabethtown

LOUISIANA
Ochsner Found., New Orleans
Louisiana San., Shreveport

MAINE
Augusta Gen., Augusta

MARYLAND
Cavett County, Prince Frederick
The Children's Hosp., Baltimore
Sinai, Baltimore
James Lawrence Kernan, Baltimore

MASSACHUSETTS
Massachusetts Gen., Boston
North Adams, North Adams
New England Med., Boston
Farren Memorial, Montague City
Jewish Memorial, Boston

MICHIGAN
Sturgis Memorial, Sturgis
Midland, Midland
St. Lawrence, Lansing
Blodgett Mem., Grand Rapids
Borgess, Kalamazoo
Coldwater, Coldwater
Marlette Com., Marlette
Amer. Legion Hosp., Battle Creek
Three Rivers, Three Rivers
St. Mary's, Grand Rapids
Bronson, Kalamazoo
St. Luke's, Marquette
Paulina Stearns, Ludington
Hackley, Muskegon
Holland City, Holland
Rehab. Inst., Detroit
St. Luke's, Saginaw
William Beaumont, Royal Oak
Sparrow, Lansing
Ionia City Mem., Ionia

MINNESOTA
Hibbing Gen., Hibbing
Lutheran, Bemidji
St. Cloud, St. Cloud
Municipal, Virginia
Ely Bloomenson Comm., Ely
Northwest, Minneapolis
St. Joseph's, Minneapolis
Gillette State, St. Paul
Northwestern, Thief River
St. Luke's, St. Paul
Rochester Methodist, Rochester
Kittson Mar Vet. Mem., Hallock
Union, New Ulm
Lake Region, Fergus Falls
U. of Minn., Minneapolis

MISSOURI
St. Mary's, Jefferson City
McCune Brooks, Carthage
Lutheran, St. Louis
St. Joseph's, Kansas City
Veterans Admin., Kansas City
Jewish, St. Louis
Midwest, Kansas City
Evangelical Deaconess, St. Louis

MONTANA
Veterans Admin., Miles City
Community Mem., Butte
Montana Deaconess, Great Falls
Montana Children's, Helena
St. James, Butte

NEBRASKA
St. Francis, Grand Island
Crete Mem., Crete
Webster C'ty., Red Cloud
Lutheran, Beatrice

NEW HAMPSHIRE
New London, New London

NEW JERSEY
Children's C'ty. Home, Westfall
New Jersey Ortho., Orange
Irvington Gen., Irvington
Hackensack, Hackensack
Dover General, Dover
St. Elizabeth, Elizabeth
Monmouth Med. Center, Long Branch

NEW MEXICO
Quadalupe Gen., Santa Rosa
Socarro Gen., Socarro
Carlsbad Memorial, Carlsbad
St. Francis, Carlsbad
St. Mary's, Roswell
Bataan Mem., Albuquerque
San Juan, Farmington
St. Joseph's, Albuquerque
Gerald Champion Mem., Alamogordo

NEW YORK
Long Island Col. Brooklyn
Hosp. for Special Surg., New York
Cornwall, Cornwall
Mt. Sinai, New York
Mt. Vernon, Mt. Vernon
Memorial, Johnson City
Southhampton Hosp. Assn., Southhampton
Alice Hyde, Malone
Mary McClellan, Cambridge
White Plains, White Plains
U. S. Naval, St. Albans

NORTH CAROLINA
Charlotte Rehab. & Spashics, Charlotte
Grace Hartley, Banner Elk
Rex, Raleigh
Northen Hosp. of Surry C'ty., Mt. Airy
Dobson Conval., Dobson

NORTH DAKOTA
V. A. Center, Fargo
Jamestown, Jamestown
St. John's, Fargo
Bismarck, Bismarck

OHIO
Freemont Mem., Freemont
Community, Freemont
Flower Mem., Toledo
Good Samaritan, Zanesville
Highland View, Cleveland
Miami Valley, Dayton
Greenicross, Warren
Mt. Carmel, Columbus
Providence, Sandusky
Mercy, Mount Vernon
Trumbull Mem., Warren
Drake Mem., Cincinnati
Massillon City, Massillon
The Children's, Columbus
Marietta Mem., Marietta
Bellevue, Bellevue
Evangelical Deacon., Cleveland
Martens Ferry, Martens Ferry
Hardin Mem., Kenton
White Cross, Columbus
Doctor's, Columbus
University, Columbus
Magnetic Springs, Magnetic Springs
Union, Dover
Greenfield Municipal, Greenfield
Van Wert C'ty., Van Wert
Ft. Hamilton, Hamilton
St. Charles, Toledo
Grant, Columbus
Grandview, Dayton

OKLAHOMA
U. of Oklahoma, Norman
Muskogee Gen., Muskogee
St. Mary's, Enid
Mercy, Oklahoma City

OREGON
Providence, Portland
Portland San. & Hosp., Portland

PENNSYLVANIA
Centre County, Bellefonte
Fitzgerald Mercy, Darby
Green County Mem., Waynesburg
Divine Providence, Pittsburgh
Good Samaritan, Pottsville
Divine Providence, Williamsport
Western Penn., Pittsburgh
Pottsville, Pottsville

SOUTH CAROLINA
Self Mem., Greenwood
Anderson City Mem., Anderson

SOUTH DAKOTA
Trinity, Minot

TENNESSEE
Baroness Erlanger, Chattanooga
Memorial, Johnson City
St. Thomas, Nashville
Cookesville Gen., Cookesville
Robertson County, Springfield
Nashville Gen., Nashville
Alexian Bros. Signal Mt., Oakridge
Oakridge, Oakridge
Parkview, Dyersburg
Maury C'ty., Columbia
Carter C'ty., Elizabethton

TEXAS
Brooks Army, Ft. Sam Houston
Amelia Brown Nur. Home, Houston
Robstown Clinic, Robstown
U. S. Public Health Serv., Galveston
John Sealey, Galveston
Texas Inst. of Rehab., Houston
Holy Cross, Austin
Flow Mem., Denton
Baptist Mem., San Antonio
Baylor Univ., Dallas
Veterans Admin., Houston
Hendrick Mem., Abilene
Medical Center, Tyler
Memorial, Houston
Hermann, Houston
Houston Children's Rehab., Houston
Providence Mem., Dallas

UTAH
Thomas D. Dee, Ogden

VIRGINIA
Central State, Petersburg
Nat'l Ortho. & Rehab., Arlington
Med. College of Va. Rehab. Dept., Old Memorial Hall
Galax Gen., Galax

WASHINGTON
Burien Gen., Burien
The Swedish, Seattle
Yakima Valley Mem., Yakima

WASHINGTON D.C.
Walter Reed Med. Center, Washington
St. Elizabeth's, Washington

WEST VIRGINIA
St. Mary's, Huntington
Potomac Valley, Keyser
Memorial, Charleston
Camden Clark Mem., Parkersburg
Vincent Fallette, Morgantown

WISCONSIN
St. Mary's, Milwaukee
Kenosha Mem., Kenosha
Veterans Admin., Wood
Wis. Neurological Found., Madison
St. Mary's, Racine
Memorial, Neillsville

WYOMING
Guthrie Rehab. Center, Thermopolis
Memorial, Riverton
Goshen County Mem., Torrington

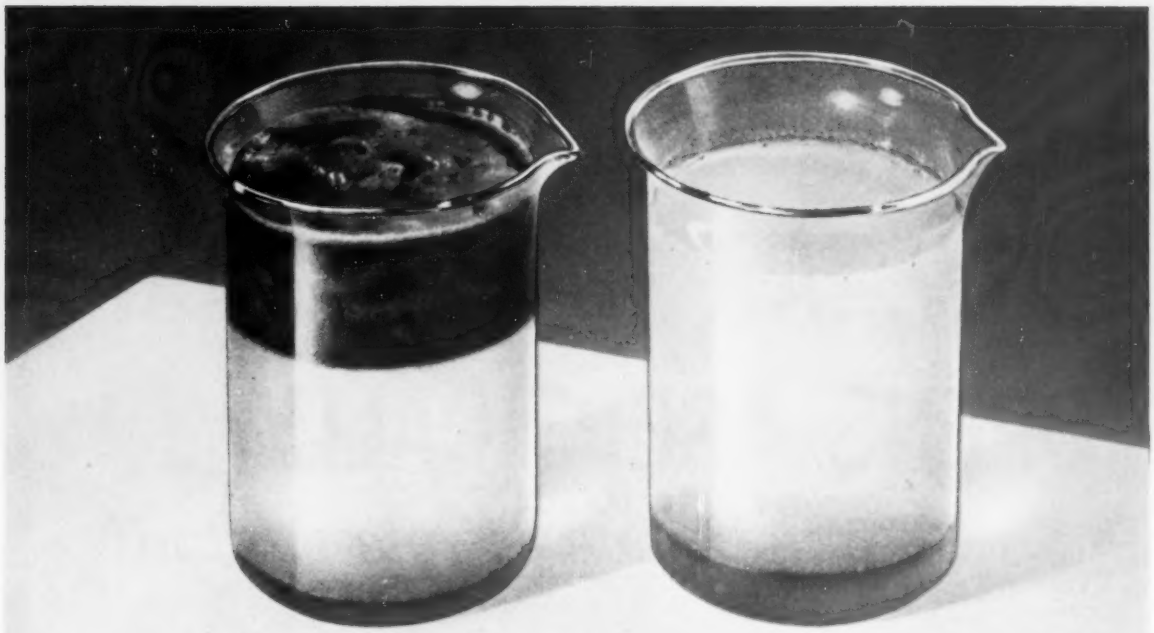
If your hospital would like to have the CircOlectric demonstrated, or use the bed on a 30-day trial basis without obligation, simply write . . . or call us today.

SURGICAL AND HOSPITAL EQUIPMENT

Stryker Orthopedic Frame Company

420 ALCOTT STREET • KALAMAZOO, MICHIGAN

Exclusive Agent for Export: Schueler & Co., 75 Cliff St., N. Y.



1

The colored material floating on top of the scrub water in the jar is actual floor tile, ground off by a too-abrasive, nationally distributed, synthetic floor pad *of recommended grade.*

2

This jar contains scrubbings from an identical area, for an identical scrubbing time. There is no solid flooring material. A Brillo #3 pad was used here. (The recommended grade.)

Reproduction of actual photograph

Are your floors being washed down the drain?

Here's what comparison tests prove about floor pads

The purpose of a floor scouring pad for use with a floor maintenance machine is to remove the traffic grime, old wax and stains from the floor. Unfortunately, some of the widely advertised, synthetic floor pads now being sold are so abrasive that they remove the floor surface, too . . . as these tests prove:

The test set-up: Two identical areas of asphalt tile floor are scrubbed with plain water for five minutes each. The same floor machine is used for each area.

AREA 1 . . . scrubbed with the recommended grade of a nationally advertised synthetic scrubbing pad.

AREA 2 . . . scrubbed with the recommended grade of Brillo *metal fiber* Floor Pad.

Procedure: After scrubbing, all of the water and free solid matter is collected from each area and deposited in identical glass beakers (see photo).

Results: The first beaker, on left in photo, shows the wash water settled in the lower part of jar. The colored matter floating on top is *actual flooring, ground from the tiles by the severe abrasive action of the synthetic pad!*

The second beaker contains the material from the section of the floor cleaned with the Brillo Floor Pad. It contains only the wash water with dirt settled to the bottom. *The minute amount of actual tile material is barely sufficient to tint the water.*

Conclusions: The floor pad used on area #1 is far too abrasive for floor-cleaning use. Its repeated use will cause serious floor damage.

Brillo Floor Pads remove dirt and grime, yet are *safe* for any floor surface. Please bear in mind that Brillo Floor Pads have a continuous record for over 20 years of safe, efficient, economical floor maintenance. Investigate before you buy!

BRILLO® Floor Pads

The safe way to beautiful floors

BRILLO MANUFACTURING CO., INC., Brooklyn 1, N. Y.

NEW CURITY PACKAGING DISCOVERY!

NOW...A PRE-PACK THAT OPENS ASEPTICALLY

...*in one simple motion!*

New S-E Pack keeps dressing sterile from package to patient.
Opens without scissors or string–dressing never touches torn, unsterile edges.

An ingeniously simple wrap now gives you Cover Sponges that remain totally sterile—even during their removal from the package. There's no contact with hands or unsterile edges. Completely aseptic, at a time when strict adherence to aseptic technique is a main line of defense against hospital staphylococcus. 1, 2, 3, et. al.

In addition to much wanted safety, you have the much proven pre-pack efficiency that yields steady dividends in terms of time gained, labor spared and money saved.

For the latest—as well as the safest—in hospital dressings, see Curity.

1. Burnett, W. E.: *Program for Prevention & Eradication of Staphylococcic Infections*, J.A.M.A. 166: 1183-84 (March 8) 1958. 2. Adams, R.: *Prevention of Infections in Hospitals*, Am. J. Nurs. 58:344-48 (March 1958). 3. *Medical Authorities Recommend Ways to Control Infections*, Mod. Hospital 90: March 1958, 51-54.

CURITY Cover Sponges now available in S-E Pack—no additional cost

Curity® S-E* PACK

*T.M.

Bauer & Black
DIVISION OF THE KENDALL COMPANY

S-E PACK
all one motion: pull tab . . . dressing's ready . . . one hand's free

service from headquarters

Hospitals and the aged

What is the percentage of people over 65 who are being taken care of as inpatients or outpatients in hospitals throughout the United States?

Can you suggest reference material concerning the role of the general hospital as it applies to the aged and chronically ill?

There have been studies containing data on utilization of hospitals by people over 65; others are being conducted at present. Most of these concern hospitalization rather than outpatient care. Two of these studies are:

U.S. National Health Survey; Hospitalization: patients discharged from short-stay hospitals, United States, July 1957—June 1958. Washington, U.S. Department of Health, Education and Welfare, Public Health Service, Division of Public Health Methods.

Use of Health Services by Aged. Health Information Foundation, Vol. VIII, No. 4, April 1959.

With regard to the role of the general hospital in the care of the aged and chronically ill, there is a considerable amount of material on the subject in hospital literature. The following books contain excellent documentation and recommendations:

Commission on Chronic Illness, Vol. 11, Cambridge, Mass., 1956, *Care of the Long-Term Patient.* Published for the Commonwealth Fund, Harvard University Press.

Hospital Care in the United States. Commission on Hospital Care, New York, Commonwealth Fund, 1947.

Nicholson, Edna, *Planning New Institutional Facilities for Long-Term Care.* New York, Putnam, 1956.

The views of this Association concerning the role of general hospitals in the care of such patients are contained in a statement on the American Hospital Association Program for Care of the Chronically Ill and of the Aged, approved by the Board of Trustees in February 1959, and published in HOSPITALS, J.A.H.A., March 1, 1959, p. 55.

You will also find useful the publication "Selected References on Aging, an annotated bibliography" prepared by the U.S. Department of Health, Education, and Welfare, Special Staff on Aging. This is available from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. (50 cents).

—HELEN D. MCGUIRE

Retirement plans

We are interested in setting up a retirement plan for the employees of our hospital and would like any information you might have on the plans that are being used in the hospitals throughout the country.

There are many retirement plans for hospital employees. Our library will send you a description of the National Health and Welfare and Retirement Plan, which is sponsored by the American Hospital Association. This plan is managed through a nonprofit retirement association and is licensed under the insurance law of New York state. The advantages of the retirement association are that it provides transferability of benefits from one member hospital to another. It makes an economical pension plan available to large and small hospitals alike. Its cost is roughly 15 to 25 cents per patient day.

Some of the other methods used in hospitals to meet the need of a retirement plan are:

1. *Informal pensions—unfunded.* Some hospitals feel they have a pension plan if they continue a partial income to selected employees after retirement. Such benefits are usually not funded but rather charged, year by year, to the current budget. Under this arrangement, the employee usually makes no contribution to his own retirement and the employer pays the full cost.

2. *Funded pensions.* Under a funded pension plan the employer builds up reserves over a period of years to meet the promised benefits. These benefits are not paid out of the current hospital budget. Methods of handling a funded pension plan are:

(a) *On a self-administration basis.* Self-administration involves the hospital in collecting funds, paying out benefits and assuming all the risks. The risks involve loss of capital and pensioners living longer than anticipated. In a single hospital's self-administered plan it is not possible to pool the risk with a much larger group of hospitals.

(b) *Pension trust.* Under a pension trust the hospital places in the hands of a trustee (usually a bank) the management of the funds it sets aside monthly or yearly for pensions. The trustee receives a fee for its service and uses its best judgment as to investments. It may pool the investments for greater safety. However, the hospital, not the trustee, assumes any losses in the value of the trust funds.

(c) *Insured pensions.* Under an insured pension program, a hospital would turn over its funds to an insurance company for the purchase of annuities. The insurance company assumes all of the risk and guarantees the benefits even though some benefits may be paid out in the future.—JACK W. OWEN

Linen distribution systems

Please send us information on linen distribution for hospitals, including the centralized linen distribution system.

By centralized linen distribution system, we assume you mean a system whereby the clean linen is received and stored in a room adjacent to the laundry, as compared to a system where smaller amounts of clean linen are temporarily stored throughout the hospital to be distributed as needed.

In many hospitals, the centralized linen room is immediately adjacent to the laundry area and under the jurisdiction of the laundry manager or the executive housekeeper. Clean linen, both flatwork ironed and rough dried, is routed to this room and temporarily placed on shelves before

(Continued on page 106)

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

Research Proves New Vacuum Cleaner Safe for Hospital Housekeeping

Eliminates Bacteria Feed-Back

The new Kent Microstat* Vacuum Cleaner can be used safely even in patient areas of hospitals. Its special filter traps all bacteria before the air it takes in is exhausted. Recent tests demonstrate the 100% efficiency of the Kent Microstatic* Impaction Filter in preventing microorganisms of submicron size and larger from escaping in the exhausted air.[1]

Thus it is superior to "ordinary" cleaners which aggravate the airborne bacteria problem by recirculating microorganisms in the exhausted air.

[1]*Allen, H. F.: J.A.M.A. 170:261, 1959; and further research data to be published.*

Gently diffused, upward slanted exhaust... another Kent exclusive

The gently diffused, upward deflection of the Microstat's exhaust stream minimizes dangerous turbulence which could dislodge bacteria laden dust particles from uncleaned portions of floors, walls, ceilings, or ledges.

Research determinations have shown that "ordinary" machines create such turbulence in a test area that a substantial increase in the count of airborne bacteria is observed. After long periods of running the Kent Microstat in the same area under the same test conditions, the airborne bacteria count remained very near the resting level.[2]

[2]*Wheeler, W. E.: Data to be published.*

High-Powered for Fast Cleaning

The efficiency of any vacuum cleaner is determined by the volume of air drawn through the machine.

Due to the Kent Microstat's powerful twin motor-fan system, the unit draws 145 cubic feet of air per minute through the three filters and the muffler. The Microstat is rated among the most efficient vacuum cleaners now on the market.

Kent's efficiency is important to the hospital executive. It assures more work in less time . . . with complete safety.

Quiet Kent Microstat Easy on Patient's Nerves

The Kent Microstat Vacuum Cleaner is amazingly quiet.

Its special patented muffler is designed on the "reverse megaphone" principle, reducing motor and exhaust noise to a virtual whisper.

As every hospital executive knows, ill people are often extremely sensitive to unpleasant sounds. Excessively high noise levels have precluded the use of "ordinary" vacuums in or near patient areas. Kent Microstat's hushed operation is thus a marked advantage.

Only Microstat Combines all these Features

... 100% efficient Microstatic Impaction Filter traps all bacteria.

... gently diffused exhaust doesn't dislodge bacteria-laden dust from uncleaned areas.

... exceptional quietness for patient-area use.

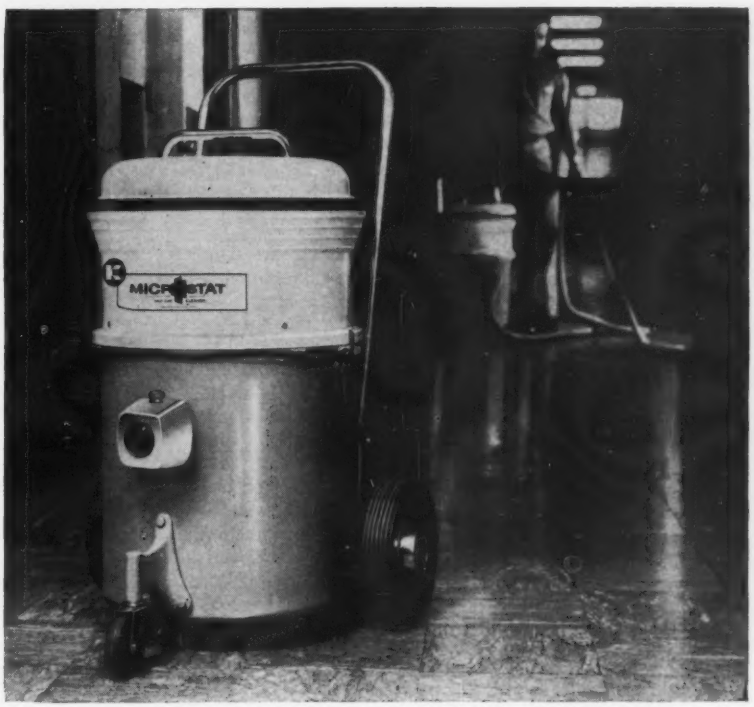
... does every cleaning job—including wet pick-up—quickly and efficiently.

For a safer and a cleaner hospital, build your housecleaning procedures around the Kent Microstat.

The Kent representative will be happy to explain how the Microstat fits into thoroughly tested and safe housekeeping technics. Ask him to demonstrate the Microstat's revolutionary features.

For complete information, ask your Kent distributor or write The Kent Company, Inc., Rome, New York.

*Trademarks of The Kent Company, Inc., Rome, N. Y.



The New KENT MICROSTAT*

SAFE ▾ QUIET ▾ EFFICIENT

Visit the Kent Microstat exhibit, Booth 237, A.H.A. Convention, New York, August 24-27.

Lehn & Fink
PROFESSIONAL DIVISION

staph newsletter

FIRST OF A SERIES WITH SIGNIFICANT SUGGESTIONS FOR CONTROLLING CROSS INFECTION

DID you notice the line just above? Actually, that explains our feeling, and our hope, that you would be interested in hearing from us through STAPH NEWSLETTER at fairly frequent intervals. "Staph" is such a big subject and big problem at the moment that we want to be of as much help as possible in calling news items about its control to your attention. Or perhaps just making comments growing out of our own experience with its control. Our main concern is helping you curtail cross infection in your own hospital. Staph comes first, of course, but if we occasionally mention other problems—TB, for instance—we hope you'll understand and watch for the next newsletter in the series.

This year is Lehn & Fink's 85th anniversary . . . and we definitely feel like celebrating. Not because we're so old but because we like to feel that we have made progress during that time—and will continue to in this period when the early concepts of keeping the hospital environment aseptically clean are being put to such severe tests. Lysol® disinfectant was originally developed in 1886 in Europe only a few years after Lister first presented his theories on aseptic surgery to the world—and has been used in hospitals in this country ever since the turn of the century. Today, with its non-toxic improved formula, Lysol is the most widely used disinfectant in the world.

Eliminating blankets as a constant source for spreading staph can be accomplished by confining use of a blanket to one patient and, when washing between patients, adding a phenolic disinfectant solution during the laundry procedure. In a recent A.H.A. Hospitals article, Dr. Otto H. Ravenholt and his co-workers confirm their laboratory findings in use of Amphyl® when laundering blankets taken directly from wards of two hospitals. Plate counts before laundering showed heavy contamination with staph. Comparison of untreated control blankets and Amphyl-treated blankets after drying definitely established the effectiveness of this procedure in eliminating staph on blankets. In a similar procedure for chemical disinfection of blankets, pillows, and personal clothing, a TB sanitarium in the West has relied upon use of Amphyl for over ten years—with no deleterious effects on blankets used regularly during that period. If you'd like the complete article, please write us. You may want to do similar tests in your own hospital.

After a 2-year study on the problem of "clean" wound infections at Minneapolis General Hospital (Hitchcock and others, Surgery 44:492, 1958) the dollar cost in excess hospital days is estimated. During one year, 45 patients required 2,480 additional days in the hospital due to staph infection. At $32.00 cost per day, the annual total cost was $79,360. Improvements in housekeeping procedures were cited as among the significant remedial measures taken.

Most everyone recognizes that every hospital has some unique problem in management and control of infections —but for hospital-wide control the establishment of an Infections Committee has come to be the basic step in any improvement program. The Surgery article mentioned above is interesting in its description of the Infections Committee "at work". You may also like to read an article in the December, 1958 issue of the A.M.A. Archives of Internal Medicine by Dr. Yow and his co-workers suggesting the precise organization and functions of the committee in relation to the individual hospital.

"By a procedure of frequently repeated, intelligently directed, and vigorously applied mechanical effort *in combination with a good detergent-disinfectant*, any surface or area whatever can be rendered clean or even sterile." Adams, R., Fahlman, B., Dube, E. W., Dube, F. J. C., and Read, S. Control of Infections within Hospitals: special reference to prevention within operating rooms. J.A.M.A. 169:1557 April 4, 1959.

Since L&F's Tergisyl® was the detergent-disinfectant used in this infection control study, we have reprints ready for your request. Dr. Adams also has some other good suggestions for cutting infections.

When is staph epidemic? Dr. Warren E. Wheeler of the Department of Pediatrics at the University of Ohio says, "Even one breast abscess in a baby is an indication of a strain so virulent that it probably should be considered an epidemic strain. Certainly two breast abscesses or several lesions in different babies due to the same strain constitute an epidemic." (Pediatrics, 23:977, 1959).

If you have a specific staph problem plaguing you, why not write us about it? Although our contribution applies to only one part of the complete infection control picture, we just might be able to help. Our research laboratories and technical advisors would be glad to work on it. And I, personally, would appreciate having you ask us. Let me hear from you.

Felix M. Bronneck

Felix M. Bronneck, Manager
Professional Division

LEHN & FINK PRODUCTS CORPORATION
445 PARK AVENUE, NEW YORK 22, NEW YORK

©1959 Lehn & Fink Products Corporation

HOSPITALS
JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

editorial notes

—old problem, new tack

THE OLD question is: what can be done about the nurse shortage? One new answer is: encourage women over 35 who have the qualifications to take professional training to qualify for professional careers in nursing.

San Francisco's Mount Zion Hospital has decided to do just this. Women over 35 have been invited to enroll in the hospital's regular three-year nursing course, starting with the fall semester of 1960.

Mark Berke, director of the hospital, says one good reason for this new policy is the fact that "mature women are more likely to remain in nursing and also to stay in their home communities, providing a stable group for hospitals to draw on".

We can't think of a better reason. Certainly, the hospital and its director have exercised imagination and taken a bold step toward alleviating the nurse shortage.

Two other factors make this seem like a good idea. One is the withdrawal rate from schools of nursing and the other is the attrition rate among nurses after graduation from nursing school. The withdrawal rate has been 32 per cent or more for the last ten years.

Statistics show that older women spend more time actively following a nursing career after graduation than do younger women. It would seem logical, therefore, to take advantage of this fact by allowing the mature woman to pursue a nursing career. The mature woman has the same potential for learning as a younger woman, Mr. Berke believes, and often has greater motivation to acquire a new skill. Further, to quote Mr. Berke, "Mature women are likely to have the compassion which is so necessary to nursing."

The attrition rate is much higher among younger women after graduation too. Studies made in Kansas City and elsewhere show that 54 per cent of the graduate nurses in the 20-29 year age group are employed, but that 65 per cent of those in the 50-59 year age group are employed. Nurses in the Kansas City study spent an average of 75 per cent of the time after graduation in active work. However, 40 per cent of the older women worked 100 per cent of the time compared with 23 per cent of the younger women working 100 per cent of the time after graduation.

Hospitals elsewhere would do well to watch the Mount Zion Hospital experiment closely. The implications of such a program are highly significant and make it worthy of careful consideration.

—high cost of fighting infection

AN OBSERVATION made frequently by those closest to the problem of controlling infections in hospitals is that half-way measures are little better than none at all. To hope to achieve even moderate success in such a program demands that techniques in every hospital department be examined critically and that work habits of every last member of the hospital staff be closely scrutinized.

This work, properly done by a hospital infections committee, is almost sure to bring recommendations for more or less drastic changes in hospital procedures that may have been routine for years. The urgency of making these changes quickly is likely to place a sudden strain on affected departments until new procedures are absorbed into regular routines. The strain is felt keenly by supervisors responsible for educating personnel in the necessity for the changes and seeing that new procedures are carried out.

But the severest strain of all is felt not by the personnel, supervisors or department heads, but by the hospital's operating budget, according to David Gee, associate director of Jewish Hospital of St. Louis.

Mr. Gee, who outlined the administrative aspects of the hospital's infection control program before a recent hospital audience, said the cost of additional personnel, supplies and equipment necessary to carry out recommendations of the hospital's infection committee have produced severe budgetary problems. Items:

- Approximately $15,000 more per year is being spent on supplies.
- There has been a 10 per cent increase in linen processed by the laundry since the program began.
- A new gas sterilizer was necessary for processing mattresses, pillows, etc.
- Some 1500 physical eximinations are given employees per year as a direct result of the program.

Even with these expenditures (and others) and the all-round tightening up of aseptic procedures, the infection control program at Jewish Hospital does not guarantee that infections will be eliminated, according to Mr. Gee. The most the hospital expects is that incidence rates will lower.

These facts about one hospital's experience with an infection control program serve to bear out another fact—one that by this time will surprise almost no one: for the present, at least, there is no easy and inexpensive solution to the problem of hospital infections. Hospitals have no other choice than to follow the best known lines of attack, expensive as they may be.

A BALANCED HOSPITAL

by THOMAS McKEOWN, M.D.

The separation of mental and chronic sick hospitals from acute hospitals is a 20th century anachronism, according to the author, as is the single-building hospital. He suggests that present problems and future needs of patients, administrators and medical people alike could be dealt with most successfully with the creation of a multiple-building hospital community, in which the patient is placed in the unit designed and staffed for the kind of care he requires.

IN THIS paper I propose to discuss certain principles which I have suggested should be observed in future hospital planning.[1] These are:

1. All facets of hospital work should be represented on a common site;
2. The centre should be planned as a number of buildings of varied size, design, permanence of structure and equipment;
3. The medical and nursing services should be provided by a common staff;
4. The relationship of the centre to the community which it serves should be much more intimate than hitherto.

It will be noted that the effect of implementation of these proposals would be a departure from two features which are firmly rooted in our hospital tradition: (1) the separation of mental and chronic sick hospitals from acute hospitals; and (2) the concept of the hospital as a single structure of more or less uniform design, providing a full range of services for selected classes of patients.

REASONS FOR DEPARTURE FROM TRADITION

At the present time hospital authorities are confronted with serious problems which appear to be insoluble within the existing framework. Three examples may be mentioned.

● Perhaps the most serious deficiency of the medical services of the Western World is the standard of care offered to the aged sick and the mentally ill. For a long time they have been a public responsibility, but it is only recently that the inadequacy of their medical care has begun to touch the public conscience. In Great Britain the introduction of a comprehensive national health service has exposed mental and chronic sick hospitals to scrutiny according to a standard formerly applied only to general hospitals. By this standard the services are grossly deficient, and the deficiencies are not easily remedied. Even if it were possible to provide adequate financial support, it is impossible to attract enough doctors and nurses. This situation is attributable to a tradition which has isolated the care of the mentally ill and aged sick, particularly from teaching and general hospitals where the ideas of doctors and nurses are formed.

● A second and almost equally intractable problem attributable to the present tradition is the mixing of patients with entirely different needs within the same building, or even within the same ward. Patients in need of little more than bed and board are sometimes found in wards catering for others who require some of the most complex resources that modern medicine has so far devised. The reverse situation—patients in facilities far below the standard required—is seen commonly in chronic sick hospitals, where attempts to bring equipment and staff to the requisite level meet formidable difficulties. Yet another example of undesirable mixing occurs in mental hospitals, where patients with considerable insight may be required to share accommodations with others who are grossly disturbed.

● A third problem, made more difficult by the traditional concept of hospitals, is that of designing and siting buildings so that they will not soon be out of date. The size and character of the hospital population must be expected to change, perhaps dramatically, in response to advances in medical knowledge and to improvement in the extra-institutional services. The transformation in bed requirements for infectious fevers, tuber-

Thomas McKeown, M.D., Ph.D., D. Phil., F.R.C.P., is head of the Department of Social Medicine, The Medical School, University of Birmingham, Edgbaston, Birmingham 15, England.

COMMUNITY

culosis and paediatrics is fresh in our minds, and there is at least the promise that a new approach to the institutional care of the mentally ill may radically alter the hitherto intractable problem of the chronic psychotic. It is the inevitability of such changes which must make us uneasy about the designs for hospitals built within the present tradition. The difficulty can be overcome to only a limited extent by flexibility of internal design.

I suggest that although they appear to be very different, these and some other problems are due basically to the two features of our tradition referred to above: (1) the separation of hospitals for the mentally ill and chronic sick from the general hospitals: and (2) the concept of the hospital as a single structure providing a full range of services for selected classes of patients. My suggestions for the modification of these features will be more intelligible if we consider first the way in which they came about.

HISTORY OF HOSPITAL SEPARATION

Hospital organization is based essentially upon the separation of three classes of hospitals—mental, chronic sick and acute. (In the present context we ignore the minor subdivisions of the general hospital system.) In fact, the types of patients are not accurately described by the types of hospital, for the real distinction is between the mentally ill, the aged sick (only some of whom have chronic illnesses), and younger patients with mainly physical illnesses.

It is easy to see how these divisions of the hospital population came into existence. They are attributable to two circumstances: first, to the fact that the various facets of the hospital problem presented to society at different times and as different problems; and second, to the need to provide for certain classes of patients from the beginning at public expense. Until the 19th century the main object of the asylums was protection of the community from the supposed risks of the insane, and the method adopted was a penal one: patients were locked up and chastised. Gradually during the 19th century the idea that patients needed care took root. But it was only recently that the possibility of investigation and treatment was seriously considered, and by then a tradition of separate administration of mental hospitals was firmly rooted.

The institutional care of the chronic sick also presented in a different form. Traditionally the problem was inseparable from that of destitution: those who were sick were often poor, and those who were chronically sick were almost invariably so. The important arm of the British hospital system which cared for the sick poor for almost a hundred years came into existence, unplanned, in 1834, when admission to a workhouse was made a condition of public assistance under the Poor Law. It is scarcely surprising that in these circumstances the concept of institutional care for the chronic sick was that of a bare minimum, wholly divorced from the investigation and treatment which from the late 19th century became the predominant interest in general hospitals.

The second circumstance which led to the present divisions of the hospital system was the need to provide for certain classes of patient at public expense. Had the mentally ill and chronic sick not been accepted as a public responsibility they would not have been cared for at all. But a very substantial part of hospital practice was under private auspices in Great Britain until 1948, and remains so today in the United States. It was inevitable that the difference in the method of finance should be reflected in a different system of administration.

HOSPITAL AS SINGLE BUILDING

In general, the hospital is planned as a single building, providing a full range of services for the patient admitted. It is true that there are certain exceptions to this principle, where two or more hospitals are located on the same site. This practice is particularly common in teaching centres, where a

paediatric, obstetric or mental hospital may be found in close proximity to a general hospital. And in some cases the buildings may share a limited range of services. But so far as I am aware there is no example of a centre providing multiple buildings which are functionally interdependent, and in which patients are located, strictly in accordance with the type of facilities and staff required for their care.

The concept of hospitals as single more or less self-contained units was an inevitable consequence of their isolation. Being separated, often by considerable distances, they had to be made independent. This meant that each building had to attempt to provide a full range of services. In the case of general hospitals this object has largely been realized, at very great cost. In the case of mental and chronic sick hospitals financial restrictions still limit the development, but the general hospital is widely regarded as the model to which they should approximate.

But the effect of independence of the various classes of hospitals is not only that it makes it impossible to economize by sharing services. It also prohibits exchange of patients. If an individual no longer needs the service of a general hospital, he cannot readily be transferred to a unit more modestly equipped and staffed. If an aged patient in a chronic sick hospital becomes acutely ill, he cannot always be admitted to a ward suitable for his care. Mental hospital authorities often object to admission of elderly patients whose state of mind does not make it essential for them to be admitted, while those responsible for the chronic sick understandably complain of retention of disturbed patients who should be in mental hospitals.

This mixing of patients with different needs is undesirable on both economic and humanitarian grounds; it occurs because the present division of the hospital population between buildings and between administrations does not correspond to patients' medical, nursing and social needs. Given the premises that all patients are equally a medical responsibility, that gross variations in standards of care are unacceptable, and that mentally ill patients present no threat to the community or to other patients—premises which are now widely acceptable to progressive opinion—we must evidently find some new basis for the arrangement of the hospital population. The classification which follows is an attempt to provide such a basis by an analysis of patients' needs which cuts sharply across the traditional boundaries.

CLASSIFICATION OF PATIENTS

We have attempted to classify all Birmingham patients in hospital according to their medical, nursing and social needs. A record card was completed for each of approximately 8000 patients (drawn from a population of a little over 1.1 million) by a member of the university staff, after discussion with the doctor responsible for his care. Information about nursing requirements was provided by the nursing staff. The assessment began some years ago in chronic sick hospitals,[2] was extended to mental hospitals,[3] and will be completed in 1959 when data for patients in all other hospitals become available. From these records the patients were placed in four classes:

1. Those needing the full resources of a modern hospital—skilled nursing, laboratory investigation, surgery, etc.

2. Those needing limited hospital facilities, essentially simple nursing care without mental supervision, because of physical illness.

3. Those needing limited hospital facilities, essentially supervision and training, because of their mental state.

4. Those needing no hospital facilities and retained chiefly for social reasons.

The estimates of the proportions of patients in each class published previously were incomplete, because data for general hospitals were not then available. However, we are less concerned with the precise figures—which might vary slightly if different observers made the estimates—than with the principle that a classification of patients according to needs should cut across the traditional divisions of the hospital population and should provide the basis for future planning. A few points must be emphasized.

It is not suggested that an analysis of the contemporary hospital population in England provides an exact assessment of needs in other countries, or of future needs in England. What is suggested is that it is the most suitable basis for planning here at the present time (a similar analysis would be needed elsewhere), and that the hospital community should be designed so that it can respond to the inevitable future changes in the size and character of the institutional population.

In practice it may be found that the four-fold classification is not the best. But so far as can be judged without experience of the administration of a centre based on it, the classification suggested seems to us to bring together patients who have most in common in respect of the buildings, equipment and staff required for their care.

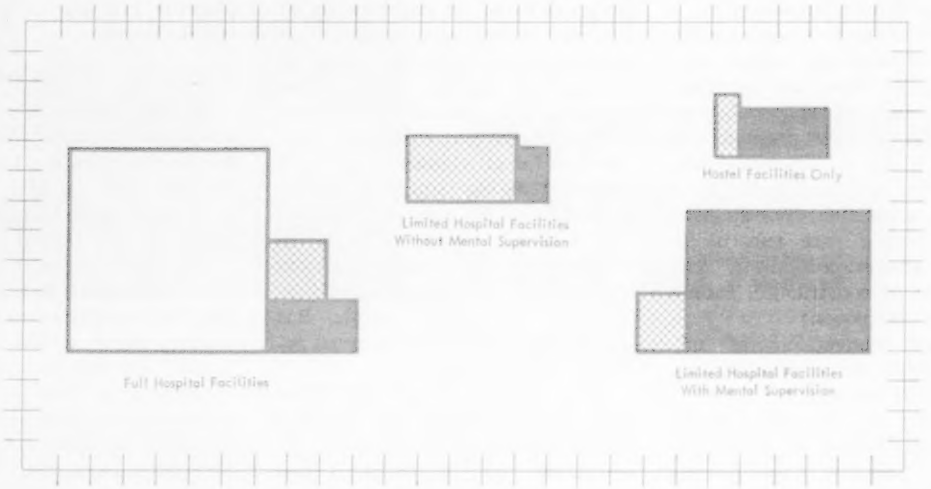
It is recognized that patients in the third class—said to need limited hospital facilities consisting of supervision and training because of their mental state—may benefit from skilled medical and nursing care. Many of them undoubtedly need psychiatric treatment, training and employment, and it is upon the adequacy of these services that hope of reducing the size of the chronic mental hospital population at present rests. All that is implied by the classification is that the nature of this care is not such as would make it imperative to provide it in a building equipped with the resources needed by patients in the first class.

Within each of the four classes there is considerable scope for variation in staffing and care which could profitably be reflected in the design of the buildings. For example, a small proportion of the patients in the third class are in bed, and need simple nursing services in a traditional ward. At least four-fifths are ambulant, however, and should not have traditional ward-type accommodation. The scope for variation of staff and accommodation for the mentally-ill has been discussed fully elsewhere[4].

It is not suggested that patients in the fourth group require no care or assistance. Many of them need employment and all of them need

Figure 1 Present Division of Hospital Populations

Figure 2 A Balanced Hospital Community


Hostel Facilities Only
Limited Hospital Facilities Without Mental Supervision
Full Hospital Facilities
Limited Hospital Facilities With Mental Supervision

a home. All that is to be inferred is that neither of these requirements would make it desirable for them to be in hospital if more suitable accommodation were available.

CLASSIFICATION AND PLANNING

Let us now consider the application of a classification of this kind to the planning of future hospital accommodation. We start with the premise that we shall ignore the contemporary divisions of the hospital population, and will plan strictly according to patients' needs. The accompanying figures show a schematic representation of the present hospital population, and its redistribution on the basis of the above classification.

There would clearly be considerable advantages in redistributing hospital patients in order to bring together those who have common needs. The question arises whether the four major classes should be catered to on the same or on a different site. Elsewhere I have discussed the advantages of a common site, served by a common staff[1]. These advantages may be summarized as follows:

1. It would make it possible to raise the standard of care of all patients to a reasonable level. At the present time it is quite impossible to attract enough doctors and nurses to mental and chronic sick hospitals. So long as these hospitals are isolated, they must depend on recruitment of staff prepared to devote themselves exclusively to these services and the difficulties will remain. They can be overcome only by placing these hospitals close enough to the general hospitals to make it possible for the same staffs to serve both. This view rests on the belief that most doctors and nurses would be prepared to make a contribution to the care of the mentally-ill and chronic sick, although they will not do so if it means cutting themselves off from their main interests.

2. It would make it possible to avoid mixing patients with different needs in the same unit. Each building would be designed, equipped and staffed in accordance with the needs of those admitted, and under a single administration patients could be transferred from one unit to another as their needs change. Let us note that this would involve no greater movement than already occurs, except to the extent that patients would be transferred from a unit when it was obvious that it was wholly unsuited —either because it was too simple

or too elaborate—for their requirements.

3. It would provide much greater flexibility in the use of buildings and staff. As needs change it would be possible to convert equipment and staff to alternative use with a minimum of disturbance if they were located on the same site.

4. It would be more economical than the contemporary hospitals. The initial cost of a fully equipped centre for a large population would of course be very great. But there are several reasons why it would be cheaper than any other means of providing equivalent services.

- There would be no duplication of expensive facilities or mixing of patients with different needs.
- Three of the four major units could be of relatively simple construction. So long as hospitals cater for such mixed populations the question of how permanently to build is almost unanswerable. (Expensive facilities must have adequate protection; yet patients needing simple care can be in cheaply constructed units. The same type of construction cannot serve both purposes.)
- Simple conversion of unwanted units to alternative use would avoid waste.

5. Among the attractions of the common site served by a common staff is the fact that it would bring some of the most intractable of medical problems to the attention of research workers from whom they have hitherto been obscured. Under the existing administration a large part of the hospital population is seen by only a very small number of people. For example it is only recently that the problems of ageing and degenerative disease, and of chronic psychosis, have had much attention, and already there is promise of advance in knowledge and practice.

6. Perhaps the most attractive feature of such a hospital centre is, however, that it would make it possible to establish a tradition under which, for the first time, all patients are accepted equally as a medical and nursing responsibility and interest. It is a serious limitation of our medical schools that however adequately they teach the principles of pathology and the practice of clinical medicine, they do not impart a clear conception of the nature of the medical problem or obligation. This is largely attributable to the unrepresentative character of the work of teaching hospitals. It is as true in New Delhi as in New York that students' concept of medicine is determined, not by visits to peripheral hospitals or exhortations from teachers of preventive and social medicine, but by what they see of the practice of their clinical teachers. It is this consideration which makes these proposals, applicable to all hospitals, specially significant in the teaching centre.

A BALANCED HOSPITAL COMMUNITY

We may now summarize the proposal based on classification of patients according to needs. It is suggested that hospitals should be planned as multiple buildings on the same site, served by a common staff and providing complementary services for all classes of patients, rather than as single buildings providing a full range of services for selected groups. Clearly so fundamental a change in the organization of hospitals must be initiated by medical people. But for its implementation we must rely on the architect.

There is little doubt that given such an opportunity the architect could transform the hospital. As conceived today it looks at best like a block of flats and at worst like a progressive factory. Quite apart from the limitations of function which have been the theme of this paper, the traditional hospital is a forbidding structure which introduces the sick patient and his relatives into an alien world. For acutely ill people brought in when they are unconscious and discharged almost as soon as they can walk, this may not be a serious objection. But for the substantial number of hospital patients who are ambulant, and whose stay is measured in months or years, the general character of the hospital scene is of first rate importance.

What is needed is to create a domestic rather than an institutional atmosphere. This can be done by reducing the scale of the buildings, by introducing variety of structure and design, and by separating the hospital buildings by other amenities—shops, restaurants, a theatre, etc.—essential to the welfare of a considerable resident population. Let us note, therefore, that while the primary reasons for suggesting the creation of a balanced hospital community were functional ones, not the least of its attractions is the possibility which it offers for an imaginative transformation of the hospital scene. There can be little doubt that if architects are given the opportunity to apply to such a hospital community the ideas which have been so successful in other fields, the results would be equally attractive. In these circumstances the analogue of the hospital would no longer be the somewhat forbidding block of flats, but the well-planned housing estate or university centre.

SIZE AND FEASIBILITY

Finally, we must consider two practical questions. What should be the size of such a hospital community? And would it be feasible in present circumstances in Great Britain or the United States?

Without experience of its operation it is quite impossible to be definite about the size of the community which would be most efficient. All that can be said with confidence is that it should be neither so large as to be administratively unwieldy, nor so small as to be uneconomic. The difficulty is the greater because there are differences of opinion about the optimum size of a traditional hospital, or indeed of any institution—such as a university hostel—accommodating a resident population. Moreover, decision does not rest solely on economic grounds. Given complete freedom of choice, however, one would like to see the possibilities of the scheme explored at a centre providing approximately 1500 beds in relation to a population of about 200,000. But there is no reason to doubt that the essential features of the scheme—one site, multiple buildings and a common staff—would be applicable to much smaller populations in towns, or even in rural areas.

The difficulties in planning hospitals on these lines are considerable, but not insuperable. Most of the existing buildings are unsuitable, and many of the sites on which they are placed are too

(Continued on page 107)

Clara Maass Memorial Hospital
BELLEVILLE, NEW JERSEY
CLARA MAASS MEMORIAL HOSPITAL
is pleased to award this
Certificate
to
For completion of a course in
Baby-Sitting
May 12, 1959

(ABOVE) Girls who have completed the baby sitters course at Clara Maass Memorial Hospital assist nurses in the pediatrics department. (UPPER, LEFT) A diploma certifies completion of the baby sitters course. (LOWER, LEFT) Graduates of the baby sitters course learn first hand the meaning of recreational therapy when they work with children in the hospital.

HOSPITAL CONDUCTS COURSE FOR BABY SITTERS

by ALBIN H. OBERG

"BABY DIES from overdose of aspirin." "Child seriously injured as a result of fall." "Baby sitter attacked by unknown assailant." These statements could all be newspaper headlines; a reading of the story would disclose that these drastic events all took place while Mom and Dad were out dancing and junior was left home with the baby sitter, a neighborhood girl from down the block. The neighborhood girl, barely in her teens, had been asked to take on an adult responsibility, in many cases, without supervision or training.

Aware of this problem and the needs of the community, the Clara Maass Memorial Hospital of Belleville, N.J., has instituted a course for teen-age baby sitters. Two weeks before the five-week course was scheduled to start, enrollment was closed with 77 applicants.

The course was available as a community service to high school girls in the hospital service area. Instructors volunteered their services for this project.

FOUR LECTURES

The first lecture of one and one-half hours was under the direction of a child psychologist. His course covered such subjects as the parents' responsibility to the baby sitter, the baby sitter's responsibilities, childhood fears, insecurity and the child-baby sitter relationships.

The second lecture was under the direction of the obstetrical supervisor. Her lecture covered subjects pertaining to the care of the baby—diapering, feeding, formula preparation, bathing, etc. Practical demonstrations were arranged with the aid of the local diaper service.

Childhood diseases and safety were covered in the third lecture, under the direction of the hospital pediatrician.

Lecture four was in three parts. Speakers included the police chief, fire chief and a representative of the telephone company. How to answer the doorbell, what to do about prowlers and other problems of personal safety were covered by the police official. Fire hazards and fire safety were covered by the fire chief. Of equal importance was the discussion on telephone answering and message taking.

The final lecture in this series dealt with recreational therapy. The girls were given ideas about entertaining small children with games, songs and stories.

This course was designed not only for the one night baby sitter, but also for the girl who might plan on spending an entire summer in this activity. The graduates were felt to be qualified to assume the responsibilities.

At the completion of the course, graduation exercises were held in conjunction with the hospital's annual hospital week volunteer award ceremony. All graduates of the course have been invited to participate in the volunteer program as aides in the pediatric department. ■

Albin H. Oberg is executive director, Clara Maass Memorial Hospital, Belleville, N.J.

TODAY'S PRACTICAL

CONCEPTS BEHIND HER EDUCATION

by HILDA M. TORROP

Practical nursing schools should train their students to provide quality care and sustained performance, according to the author. She discusses practical nursing education and service in terms of its place in the variety of nursing programs, economic and job satisfaction factors and present and foreseeable trends.

A PROFILE of the trained practical nurse, 1959 model, shows a man or woman between the ages of 18 and 50 with two to four years of high school education, a general intelligence level of 90 and a strong motivation toward nursing service. Approximately 80 per cent are married and have been employed in a variety of jobs prior to entering a school of practical nursing.

She has completed a 12-month training program consisting of a 4-month foundation period (including some hospital experience), followed by an 8-month period of full-time supervised clinical experience on medical, surgical, pediatric and obstetric services, which may have been augmented by geriatric or psychiatric experience. She has learned the manual skills taught in the professional nursing school curriculum. Administration of medicines is the latest procedure to be recommended for inclusion.

In company with all workers, practical nurses vary in ability, in personality and in adaptability, but it can be said that upon graduation from a good school of practical nursing they are able to give competent nursing care in any clinical service of the hospital.

This rapidly growing nursing group can be described as the foundation of nursing service. They begin and complete their nursing programs with the intention of becoming full-time, all-time nursing service people. This is their greatest asset to the hospital administrator. In time these thousands of service personnel will be a stable foundation upon which the various professional nursing programs can be projected.

It is a psychologically important fact that this corps of nurses must consistently extend itself to meet the demands made upon it. To be nursed "up to" is something that is tangible and very comforting to the patient.

A definite correlation exists between the practical and professional nursing student's investment of time and the salary she will receive as a graduate. The general wage scale gives the practical nurse 75 per cent of the professional nurse's salary at the one comparable level, i.e., staff nursing service. This compares poorly with secretarial or trade salaries, but is approximately $200 a month without maintenance.

The identification of job satisfactions is vitally important to help assure that this valuable worker will not rotate out of the vocation. A sense of personal worth, career prestige value, recognition of ability, increased responsibility—all are more important than salary.

The practical nurse's job stability has never been translated into dollars and cents but the amount must be impressive. Studies rate her on the same level with the hospital administrator.*

Present and foreseeable trends point to a trained practical nurse corps of large proportions. Forty per cent of high school students drop out before graduation and trade programs for women are few indeed, compared to the number and diversification of courses for men.

The Curriculum and Accrediting Committees of the National Association for Practical Nurse Education and Service, Inc. have been compiling and analyzing data for 18 years and work closely with the Hospital Advisory Council.

RECOMMENDED CURRICULUM

These committees recommend changes in the training program to meet the national need for more and better patient care and in the light of demonstrated practical nurse ability.

The task is made difficult by the variation in standards between schools in different states and between schools in the same state. Licensing laws encourage the development of good schools in some states and the reverse in others.

The curriculum content, physical facilities, teacher preparedness, clinical experience and selection of students, should be uniformly of such excellence that hospital administrators would be assured that patient safety and quality nursing service would follow employment of trained practical nurses.

It behooves the schools to prepare their students for the nursing service that would be purchased by the hospital administrator who is looking for quality, quantity and sustained performance.

OUTMODED CONCEPTS

Concepts of practical nursing were developed when graduates were few and practical nurse employees in hospitals equally rare. The halo concept has been placed around certain procedures, such as charting, catheterization, and

Hilda M. Torrop, R.N., is executive director, National Association of Practical Nurse Education and Service, Inc.

This article has been adapted from a talk given at the Western Hospitals Convention, Salt Lake City, May 5, 1959.

*As reported by a representative of the Public Health Service at the American Hospital Association 1956 annual meeting.

NURSE

HOW SHE IS FILLING THE NURSING GAP

by CORDELIA W. KELLY

Results of a recent study indicate that the practical nurse's services are being utilized by the hospital that trains her, according to the author. She discusses the facts elicited by the study and presents the conclusions indicated by them.

THE TRAINED licensed practical nurse in hospitals today is taking on more and more duties and, in most instances, both the patient and the hospital are well satisfied. The excellent training and supervised practice she has in an approved school of practical nursing prepare her to give nurs-

(Continued on next page)

Cordelia W. Kelly R.N., is now a free lance writer. She was formerly associate editor of the *American Journal of Nursing* and Editor of *Practical Nursing*, and has had experience in hospital administration and nursing.

medicine giving. Within many hospitals the practical nurse is not allowed to chart or give medicines from 7 a.m.—3 p.m., but by some feat of alchemy, becomes steadily more competent with the passing hours, so that by 11 p.m. she is carrying the entire nursing service on a ward. One of our staff calls this "sunshine" and "moonshine" nursing. Think what it would mean if this service could also be made available at 7 a.m.

The persisting illusion that all practical nurses are equal must be dispelled in the interest of better utilization of the individual. Postgraduate courses are preparing carefully selected men and women for service in the operating room, the intensive care unit, the premature nursery, and for skilled nursing care of neuro and thoracic surgery cases. Practical nurses are serving as assistants to professional nurse instructors, and to head nurses. In practice, this works out (to paraphrase George Orwell's *Animal Farm*) that all practical nurses are equal but some practical nurses are more equal than others!

ATTITUDINAL TEACHING

The importance of attitudinal teaching cannot be overemphasized. While the practical nurse is still a student she should develop a citizen awareness of the complex nursing service needs of the hospitals, whose patients cannot be put in deep freeze on nights, holidays or weekends. She should become aware that the dignity with which she wears her uniform is both a practical and an aesthetic responsibility and that membership in her state association is a privilege and a guardian of her future. Instructors do not always accept these precepts as primary teaching assignments nor appreciate the influence on patient opinion exerted by practical nurses.

From the community hospital, and recruitment point of view, this education program is vitally significant. For the citizen it is a partial answer to long-time nurse shortages; for a large segment of the population that cannot and will not enter the professions, it is an interesting and accessible career; for the hospitals, it has proved a source of stable, highly motivated workers.

Practical nursing as a career is in its infancy. Approximately 22,000 practical nurses will be graduated this year; 60,000 could be placed immediately. With current figures of 27 million patients requiring but not getting long-time care, (5000 of which need intensive nursing service) we have a nursing problem of the first magnitude in this area alone.

The source of nursing power should be studied and we should decide what it means to each of us. ■

table 1

NUMBER OF BEDS	NUMBER OF HOSPITALS
Under 25	0
25- 49	1
50- 99	8
100-199	17
200-299	18
300-499	23
500 or over	17
TYPE OF SERVICE	
General	81
Children's	2
Tuberculosis	1
LENGTH OF STAY IN HOSPITAL	
Short-Term	82
Long-Term	2

table 2

NAME OF STATE	RET'D.	NAME OF STATE	RET'D.
Arizona	3	New Mexico	3
California	1	New York	3
Colorado	4	Ohio	22
Dist. of Columbia	4	Oklahoma	1
Georgia	1	Pennsylvania	4
Illinois	1	South Dakota	1
Indiana	7	Texas	2
Kansas	1	Utah	3
Maine	3	Vermont	4
Massachusetts	1	Virginia	2
Michigan	7	West Virginia	6
New Jersey	1	Total	85

(one unusable)

table 3

	OFTEN	SOME-TIMES	NEVER	UNAN-SWERED
Catheterization	53	20	11	
Insert Retention Catheter	36	30	16	2
Bladder Irrigation	46	21	16	1
Change Surgical Dressing	28	38	18	
Apply Sterile Hot Packs	35	35	11	3

table 4

	OFTEN	SOME-TIMES	NEVER	STU-DENTS ONLY	UNAN-SWERED
Prepare or pour oral medications	19	25	33	1	2
Give oral meds.	21	26	30	1	2
Prepare subcutaneous meds.	17	23	39	1	
Give subcutaneous meds.	16	24	39	1	
Give insulin	21	24	34		1
Give intravenous meds.	1	2	74	1	2
Give intramuscular meds.	18	22	38	1	1
Give rectal meds.	14	31	35		
Insert vaginal suppository	15	31	34		
Instill eye drops	18	27	34	1	
Instill nasal drops	22	31	26	1	
Instill silver nitrate in eyes	10	14	53	No obstetrics 2	1

ing care that is too complex for the paid or volunteer aide, yet does not necessarily require the advanced skill of the professional nurse. Additional instruction as a graduate on the job often adds to her skills.

Some interesting facts resulted from a questionnaire study made recently by the Hospital Advisory Council of the National Association for Practical Nurse Education and Service, Inc. The council initiated the study to help answer the following questions:

1. To what degree are hospitals that actually assist in training the practical nurse utilizing her services as a graduate?

2. Does the trained licensed practical nurse do on the job the procedures she learned in nursing school?

3. Is the trained licensed practical nurse helping to fill the gap in nursing services?

4. Is the curriculum recommended for NAPNES-approved schools of practical nursing preparing the practical nurse adequately for the duties she is asked to perform?

The questionnaire consisted of four "yes or no" questions and a list of 68 nursing procedures to be checked as being done "often," "sometimes," or "never" by the trained licensed practical nurse in the hospital completing the questionnaire. The questionnaire was mailed only to hospitals affiliated with NAPNES-approved schools of practical nursing. These hospitals are under contract to provide sufficient clinical experience for the students under the supervision of a professional nurse. It seemed reasonable to expect that these hospitals would be thoroughly acquainted with the practical nurse, her abilities, and her potentialities. If she were satisfactory, it might be assumed that the hospitals would employ her in large numbers as a graduate. If not, lack of faith in a product they had helped to produce would become apparent.

Furthermore, the council felt that the questionnaire should seek information about the trained licensed practical nurse only, since this would assure that she had had formalized preparation in an approved school of practical nursing

and had passed the state licensing examination in the state where she works.

The questionnaire was mailed to 151 hospitals; 85 were returned (only one of which could not be used), representing 55.6 per cent of usable returns. As in most studies of this type, an occasional question was unanswered or item unchecked but, on the whole, the information requested was supplied.

REPRESENTATIVE SAMPLING

Using Part II of the August 1, 1958, Guide issue of HOSPITALS, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION, as a reference, the 84 participating hospitals were classified as shown in Table 1 according to size, type of service, and length of patient stay.

The smallest hospital reporting had 43 beds, the largest 3200, exclusive of bassinets. An occasional general hospital did not provide all clinical services, such as maternity, and this was taken into consideration when tabulating the results.

The 85 hospitals that returned completed questionnaires were distributed according to states as indicated in Table 2.

FOUR LEADING QUESTIONS

To the first of the "yes or no" questions, "Do you employ the trained licensed practical nurse?" all 84 hospitals replied yes. Asked if they would employ more if available, 71 said they would; 9 said they would not, but with explanations such as "We have enough to meet our needs"; Two accredited practical nursing schools affiliate here so we have a good source of practical nurses"; or "Our budget won't permit a larger staff." One lucky West Virginia hospital replied that the local supply exceeds the demand. Four hospitals did not answer this question.

Answers to the second part of the second question—"How many more do you need?"—ranged from 3 to 87, with several hospitals giving 4, 6, 10, and 12 as the number of nurses desired. One replied "Dozens and dozens for three shifts," and another "Twelve for 3-11 and 11-7 shifts." All of the participating hospitals do employ the practical nurse and almost 85 per cent would employ more if they were available. The specific number needed—as given by 37 of the responding hospitals—totalled 623, an average of 17 for each.

The third question, "Does the trained licensed practical nurse meet the needs of your hospital?" brought these replies: Yes, 49; generally, 33; 2 did not answer the question. "Is the service she gives satisfactory to the patient?" was answered in the affirmative by 55 hospitals; 28 said generally; 1 did not answer this question. None of the hospitals gave a flat "no" answer to either of the last two questions; there seems to be little doubt that the trained licensed practical nurse is an established and valued member of the nursing staffs in these institutions.

SERVICES PERFORMED

As might be expected, the tabulated* results of the questionnaire study show that the trained licensed practical nurse often or sometimes gives bed baths and takes temperatures and pulse rates in all of the reporting hospitals; 81 reported that she takes blood pressure readings; 65 that she often or sometimes uses a stetho-

PRACTICAL nurses perform needed services on the pediatric ward. Here a practical nurse attends young patients at lunch.

* The original questionnaires and the summarized replies are on file and may be seen at the headquarters office of the National Association for Practical Nurse Education and Service, Inc., 654 Madison Avenue, New York 21, New York.

scope to count a patient's heart beat.

In nearly all of the hospitals queried the trained licensed practical nurse often or sometimes performs a large group of basic nursing procedures. These include giving enemas, perineal care, and internal douches; applying unsterile hot packs and dermatitis wet packs; changing colostomy and decubitus ulcer dressings; irrigating healed colostomies; and assisting the doctor with dressings and examinations.

Not quite as many hospitals assign to the practical nurse procedures requiring aseptic technique, as the figures in Table 3 show.

In surprising contrast to the figures in Table 3, 81 hospitals reported that the trained licensed practical nurse often or sometimes carries out isolation technique.

A few of the items on the list of procedures were concerned with so-called paper work. Results show that in all but 3 hospitals the trained licensed practical nurse charts on both the graphic and nurse's records; in 27 she *never* fills out laboratory requisitions; in 54 she *never* copies orders. Several hospitals explained that ward clerks usually do the latter two precedures. Forty-four hospitals reported that the practical nurse often or sometimes witnesses surgical permits. Only 17 allow her to take phone orders from doctors; the practice of telephoning orders is discouraged or forbidden in most hospitals, however.

DISPENSING MEDICATION

Realizing that the question of who should give medications is receiving a great deal of attention in nursing circles today, the planners of the questionnaire included 12 procedures in this area. The replies received from the 80 general short-term hospitals are tabulated in Table 4.

In both of the long-term hospitals, the trained licensed practical nurse gives all of the types of medications listed in Table 4 except intravenous medications. In one of the children's hospitals she sometimes gives oral and rectal medications and instills nasal drops; in the other she never gives any type of medication on the list. Two large hospitals reported that she never prepares oral medications but sometimes gives them; another that she never gives any medications except vitamins in the nursery; another that the antibiotics are the only intramuscular medication she gives; and another that she gives medications only to geriatric and psychiatric patients.

One 647-bed hospital, which employs 112 trained licensed practical nurses and 60 general duty professional nurses, reported the following: the practical nurse *often* prepares and gives oral and intramuscular medications and insulin; *sometimes* prepares and gives subcutaneous, rectal, and vaginal medications and instills eye and nasal drops; *never* gives intravenous medications or instills silver nitrate in a newborn's eyes.

There are several possible reasons why so many hospitals do not ask the trained licensed practical nurse to give medications, but since a practical nursing student in a school approved by the National Association for Practical Nurse Education (and this is true in most state-approved schools, too) learns to use the proper techniques in giving medicines, it appears uneconomical to never let her give them on the job. Furthermore, she, like everyone else, needs to practice a skill to retain it. Questionable job satisfaction also is implied.

ON-THE-JOB LEARNING

In one-third to one-half of the hospitals the trained licensed practical nurse often or sometimes performs procedures on the questionnaire's list that require a high degree of skill. These include inserting or changing a nasal catheter, irrigating a new colostomy or gastric suction, changing the inner cannula of a tracheotomy tube, and using suction on a patient who has had a tonsillectomy and adenoidectomy. In 3 hospitals she sometimes inserts a stomach tube (one stated "in infants only"); in 7 she often or sometimes does a rectal examination; and in 2 she sometimes gives ether in the delivery room.

All of these procedures require skills which the practical nurse does not master in nursing school. It seems certain, therefore, that she is not asked to do them on the job until she has had adequate instruction and supervised practice. Undoubtedly neither she nor a professional nurse would ever be asked to do some of them, such as giving ether in the delivery room, if a real emergency situation was not present. The significant point is that selected trained licensed practical nurses are capable of learning to do these procedures safely and well.

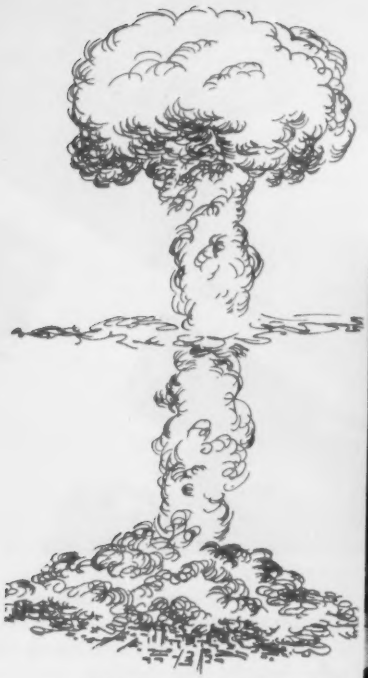
In 58 of the reporting hospitals the trained licensed practical nurse often or sometimes assists in the delivery room; in 58—including the 2 children's hospitals—she assists in surgery. In 76 she watches patients under anesthesia; in 62 she watches patients in labor. Several hospitals explained that she has "advanced training in these specialties."

Such precautionary statements are noted fairly often on the questionnaires. "Under supervision," "in selected care unit only," "in recovery room only and under supervision," and "only with added instruction" were written beside affirmative replies to several items. This is understandable and in no way detracts from the value of the practical nurse as the professional nurse's "right hand man" in giving nursing care to patients.

CONCLUSIONS

The Hospital Advisory Council of NAPNES is well pleased with the results of this study. While granting that 84 hospitals is a small sampling of the approximately 8000 hospitals in this country, their wide variation in size and location makes the data obtained from them highly significant.

The results indicate that hospitals that assist in training the practical nurse do utilize her services to a considerable degree as a graduate and do permit her to perform on the job (with comparatively few exceptions) the procedures she learned in nursing schools. The council feels that the trained licensed practical nurse definitely is helping to fill the gap in nursing service; that she could help even more if she were available in larger numbers; and that hospitals that use her services to their full potential are saving money. ■



'OPAL 58'

AT 9 a.m. the "paper evacuation" begins with the patrolmen's delivery of the evacuation order to the hospital administrators. None of the 13 hospitals taking part in the alert had been informed beforehand.

Surprise 'paper evacuation' moves 13 hospitals to nontarget area

by JERRY N. RANSOHOFF

A "PAPER EVACUATION" theoretically turned a small Ohio college town into a mammoth hospital center in "Opal 58", Greater Cincinnati's Civil Defense "Operation Alert" of December 1958.

Oxford, O., home of Miami University, is the evacuation center for the patients of 13 Greater Cincinnati hospitals who, in the event of enemy attack, would need continued medical care and could not be sent home for evacuation according to their own resources.

The plan of evacuating the entire hospital population of a metropolitan area to a nontarget area where regional hospital care can be carried on is believed to be unique in civil defense planning.

The "Opal 58" exercise came as a complete surprise to the 13 hospitals involved and analysis showed that it came off with only the minor hitches that might well be expected in such a maneuver.

The plan for evacuation of the 13 hospitals, which have an average daily census of nearly 4500 patients, was conceived after metropolitan Cincinnati had been designated a primary target area. The evacuation plan was based upon the assumption that there will be at least a week's warning, and some sort of "military tension" preceding the attack, so that there will be a possibility of evacuating the hospitals and personnel. There was no consideration given to the clearly impossible task of evacuation in the event of a surprise attack or a 15-minute warning.

It was believed that any nuclear attack with a weapon of more than nominal power would completely eliminate all hospital facilities. From a peacetime point of view, the hospitals are well situated—all within a radius of about four miles. But from a strategic aspect, such total vulnerability meant that they had to be evacuated in order to protect the patients and preserve the medical facilities for the entire tri-state (Ohio-Kentucky-Indiana) region.

EVACUATION CENTER

Miami University, 40 miles away over a good federal highway, fur-

Jerry N. Ransohoff is executive secretary, Greater Cincinnati Hospital Council, Cincinnati.

IN THE basement of the hospital, the purchasing agent and the dietitian complete their check of available food, perishable and nonperishable, that will be taken along in the "move to Miami".

THE EVACUATION phases of "Operation Alert 1958" are worked out by the Ohio Valley Civil Defense Authority chief, the Health Commissioner of Cincinnati and the OVCDA Health and Medical Services director in front of the situation board at OVCDA headquarters.

nished an ideal evacuation center. Its sturdy, modern buildings, particularly those with water and sewage facilities for large groups of students, would make excellent hospital wards under emergency conditions.

The university had laboratory space and equipment for the hospitals and radiation and public health surveillance teams. Dormitories would provide living quarters for personnel, and the students, quartered on the town "for the duration", could be trained to help care for the patients.

In addition, Miami University dormitories are almost self-sufficient. Each has facilities for feeding large groups of people and for storing large quantities of food and other supplies. With some first-class makeshift operation, the college could serve as an ideal medical center.

The idea of the "move to Miami" was conceived by the chief of the Ohio Valley Civil Defense Authority and the head of OVCDA Medical Health Service. Planning began in an area in which there was no previous guidance and a community committee was consulted for comment, consideration and criticism.

The prime questions were:

1. How would the patients being moved be selected?
2. How would the patients be moved?
3. What should be taken along?
4. How would the move be organized?
5. Is the idea acceptable to Miami University officials?

The committee included physicians from the Academy of Medicine of Cincinnati, representatives of the Greater Cincinnati Hospital Council, administrators of several of the larger hospitals, traffic engineers from the Cincinnati city government and spokesmen for the

trucking, bus and ambulance companies in the area.

COMMITTEE CONSULTS

The idea of any mass movement by ambulance was ruled out immediately. The committee agreed that under evacuation conditions no round trips could be made. The vehicles that moved the patients to Miami would make it a one-way trip and would be abandoned there or would be given other assignments.

The transportation service of OVCDA figured that 180 tractor-trailer units, 45 buses and 50 ambulances could be made available on any given day to make the move.

On the basis of this estimate, a schedule was set up assigning a quota of trucks, buses and ambulances to each hospital. The quotas were based on the average daily census of each hospital, taking into account the fact that approximately one-third of the average daily patient load could be discharged immediately. For medical supplies and food, an additional truck was assigned on a total bed basis, one truck for each 200 beds.

The next step was to set up a committee to present the evacuation plan to the board of trustees of Miami University and to gain their approval and cooperation in the plan. The trustees, recognizing the effectiveness of the evacuation plan, not only offered immediate and full cooperation, but also turned over to the committee blueprints of buildings so the OVCDA could determine which were most suitable for adaptation to emergency hospital use, which were best for administrative operations, which were best for laboratory and ancillary facilities and which could not be used at all by the hospitals.

With this groundwork, a committee went to work on a "master plan" for hospital evacuation which could be adapted without too much trouble to the needs of the 13 hospitals involved in the "move to Miami."

MASTER PLAN

The "master plan" was fairly simple. Each hospital was to make the plan an amendment to its natural disaster plan, which already had been developed. Each hospital was to set up an evacuation committee with the administrator as chairman, the medical chief of staff as deputy chairman, and to include the pharmacist, chief of central supply, dietitian, purchasing agent, director of nursing services and assistant administrator.

Instead of specifying the supplies each hospital was to bring, each was to be directed to load all of its most-needed available supplies such as linens, towels, blankets, nonperishable foods, antibiotics sedatives, narcotics, bandages, surgical supplies, bedpans, intravenous solutions, plasmas, blood typing and cross matching equipment, a small centrifuge, portable autoclaves—in fact as much as the truck or trucks could carry.

Most of the linens and other soft goods were to be transported in the personnel trucks to cushion patients during the 40-mile ride. The boxed equipment was to be loaded into the supply trucks. Sacks of potatoes, onions, and similar foods were to be loaded into available space on the buses.

The dietitian, central supply chief, purchasing agent and pharmacist were charged with working out the assembling and loading of supplies. Emphasis was on seeing that each truck left with as big a load as it could carry. Sorting and distribution was left to be done at Miami.

Under an evacuation order, the nurse in charge of each nursing unit is expected to prepare her patients who must be moved. She would see that each patient's clothing and necessary belongings are on his bed in a suitcase or big paper bag. Evacuation would begin with the top floor, east wing, of each hospital and would take successive wings, moving counterclockwise: until the top floor is cleared before starting on the next lower floor.

Each hospital would be expected to bring along all available personnel on duty at the time, as well as a pathologist, a radiologist, five general practitioners, an orthopedic surgeon, a general surgeon, an anesthesiologist, an obstetrician and a pediatrician for each 200 patients. These men would staff the big Miami University hospital when it was set up and coordinated. In the meantime, they would care for their patients during the move and at Miami.

"OPAL 58" TESTED

"Opal 58" was only a paper evacuation. But it was kept as a complete surprise from all hospitals involved until the evacuation questionnaire and letters of instruction were received.

The questionnaire involved eight basic questions and asked each administrator to determine:

1. How many patients were "in the house."
2. How many could be sent home immediately.
3. How many were too ill to move.
4. How many were ambulatory.
5. How many were to be moved in their beds or on mattresses.
6. How many required isolation.
7. How many days' supply of food and medicine were on hand.
8. How many staff personnel, nurses, practical nurses, aides, technicians, key administrative people and physicians were on hand.

The administrators were also asked to indicate any special problems that might be involved in evacuation such as heavy traffic, construction, elevators under repair, etc. The chief problems in this area came from a heavy snow which had fallen in Cincinnati several days before the proposed evacuation, heavy traffic and improper parking.

Four copies of the questionnaire were sent to each hospital so that various departments could work simultaneously in filling them out. The answers were then transferred to a master questionnaire. A stamped envelope addressed to the Greater Cincinnati Hospital Council was enclosed with each and a certificate was offered to the hospital whose questionnaire carried the earliest postmark, duplicate certificates being awarded in case of ties.

To see that everybody started out on the same footing and to dramatize the "paper evacuation," the questionnaires were distributed the night of December 1 to the various police district headquarters, with instructions that they be

(Continued on page 108)

PAINLESS RENOVATION

by G. O. LINDGREN

To renovate hospital facilities without disruption of services and loss of income, three basic principles must be observed, the author notes. He discusses the use of alternate space, the effective utilization of space and the necessity of sequence planning, using illustrations from one hospital's experience.

IN ANY TYPE of renovation or conversion of hospital facilities, the best one can do is to minimize the disruption of services and avoid losses of income. Each individual hospital must be considered a separate problem: however, the principles of planning to be applied are the same.

The first important concept in planning renovation or modernization of existing facilities is what might be called the use of alternate space. Seldom does one renovate or modernize a department or a portion of a building and, at the same time, carry on the normal hospital services. The usual procedure is to move the hospital's services or functions temporarily to another area while the renovation takes place. Such a procedure minimizes the interruption of normal services, and usually reduces the cost.

Alternate space is created in three ways:

1. By rearranging and squeezing up the space in the existing area so that renovation work can proceed simultaneously with services. This is the more difficult and expensive way and, yet it can be effective. Let me give three illustrations from our experience at Trinity Hospital:

- We made semiprivate rooms out of private rooms that were large enough. This permitted us to maintain occupancy while rooms were released as alternate space.
- We completely renovated the food preparation area and carried on food preparation without ever missing a meal. This was done over a period of several months. We first selected reach-in freezers which could be moved; we selected a reel type oven which was completely enclosed; and a straight line dishwasher. We first placed these permanently in position. Then, by the use of movable partitions we were able to carry on as the work progressed.
- Older buildings are often generous with all space—by careful planning this space can be effectively used as alternate space.

2. Sacrificing existing space which may be of two kinds:

- Income-producing space such as patient rooms.
- Nonincome producing space such as ends of hallways, lounges, etc.

Naturally, one should not use income-producing space except during periods of low occupancy.

3. New building space used in whole or in part as alternate space temporarily during the period of renovation: This is one of the most economical ways to get both alternate space and flexibility.

Alternate space, therefore, is the key to effective planning in a modernization and improvement program. It provides the needed opportunity for movement. Without it, the essential services of the hospital may be interrupted, the cost of renovation services abnormally increased, and the financial solvency of the hospital jeopardized. Since existing hospital facilities must continue to function, and since the hospital must maintain its solvency during a renovation program, it is important and necessary that alternate space be found and effectively used.

USES OF ALTERNATE SPACE

- We needed new boilers for heating and sterilization, but the plant could not be closed down at any time. Since space was needed for air conditioning equipment, standby generator, pumps, etc., it was decided to place the new boilers in a new location and use the old boiler area for air conditioning equipment.
- In the process of adding three stories to the existing south wing, it was necessary to bring all plumbing up through existing three floors, while maintaining patients in the area. We had to provide alternate toilet facilities on these floors during this time. This was done by first constructing public rest rooms and nurses' rest rooms between the south wing and the center wing on the west side of the corridor which were needed in the permanent plan. These rooms served the lower patient floors until the upper floors were completely finished. Patients were then moved up a floor at a time to the new area and workmen moved in turn to the vacated area.

(Continued on page 56)

G. O. Lindgren is administrator, Trinity Lutheran Hospital, Kansas City, Mo.

before

after

(BELOW) Patient rooms at Trinity Lutheran Hospital before renovation were cluttered and rather dark. Furniture and floors did nothing to lighten a patient's spirits. (RIGHT) After renovation patient rooms are pleasant places. Modern conveniences, built-in furniture, drinking and plumbing fixtures, and a television set contribute to patient comfort.

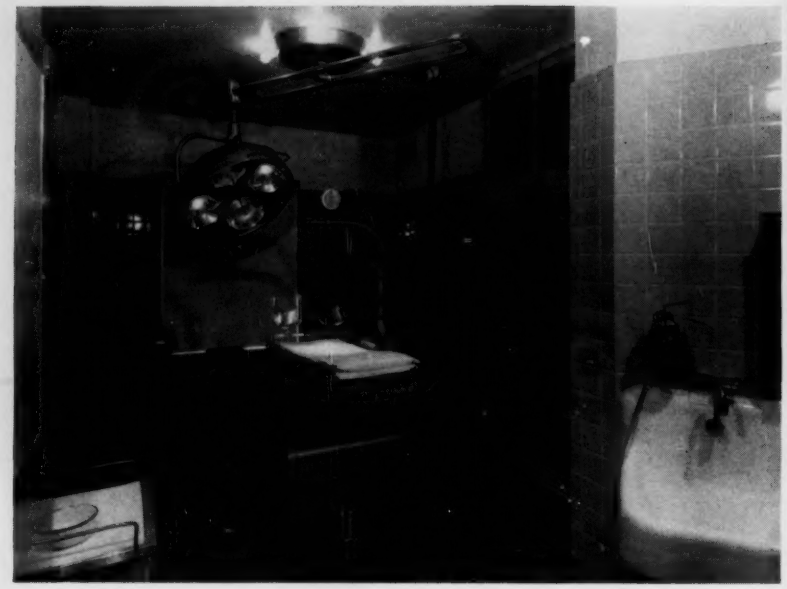
PATIENT ROOM

DIET KITCHEN

(ABOVE) The old kitchen at Trinity Lutheran Hospital had old-fashioned sinks and iceboxes, little working area and less storage space. The single light was inadequate. (RIGHT) The renovated kitchen is spacious, well lit and easy to keep clean. Modern equipment and functional layout contribute to the kichen's efficiency and ability to feed 600 people.

before

G U OPERATING ROOM



after

(ABOVE) The old genitourinary operating room at Trinity Lutheran Hospital and old fashioned equipment and poor lighting. (RIGHT) The new room is outfitted with the most up-to-date equipment, has commodious storage space and modern operating lights. The tile walls are easy to wash down.

The contractor could thus work on a whole floor at a time.

• The obstetrical area was permanently located on the new third floor; then the surgery was moved from the fourth floor of the center wings to temporary quarters in the area vacated by the obstetrical department while the surgery was being renovated. When surgery was moved into its new facilities, the old obstetrical area was converted to patient space.

UTILIZATION OF SPACE

The second concept that should be properly understood is effective utilization of space—alternate space or permanently assigned space. Such utilization depends on a proper understanding of the functions to be performed in the area and an arrangement of equipment and facilities to best expidite the function. Planning within the limitations of an existing building always requires compromises, but ingenuity and resourcefulness can make the compromises very acceptable.

• Many hospitals have empty beds on their obstetrical floors that they cannot use because of physical arrangement.

In planning our floor we alloted the south half of our H-shaped building for obstetrical patients, dividing at the stair in the middle of the center wing. The north half of the center wing can now be used either for obstetrical patients or clean medical or surgical patients.

The patient-to-nurse call system is wired so that each room can be switched separately to either the north or south nursing station as desired. This gives us full flexibility in the use of these beds.

• In planning the installation of a modern dishwashing machine, the architect provided a space of 3 ft. x 5 ft. at the feeding end of the dishwasher with a cleaning table on the right side—15 sq. ft. of space for one worker. By placing a work table behind him we reduced the space in which he moved to 36 in. x 30 in. or 7.5 sq. ft. We were able to give him more work table space necessary for efficiency and, at the same time, reduce wasted motion. With a good arrangement, a worker can be much more efficient in a small space than he can in a large one.

• The dietary department had to be planned to function for a hospital facility of 200 beds in the same space that was provided for 125 beds in 1925. This was about 40 sq. ft. per bed. By eliminating floor diet kitchens, partitions, halls and other waste space, we ended up with 20 sq. ft. per bed—and a much more efficient arrangement.

We can now feed 200 patients and 400 employees with greater ease and efficiency than we did the smaller numbers. There is much less wasted motion. Modern equipment, good light, and good ventilation contribute to the workers' sense of well-being and thus to his efficiency.

SEQUENCE PLANNING

The third concept in renovation is that of sequence planning. Planning the construction of a new building is a relatively simple process compared to planning a modernization and renovation program. Once the plans have been completed and adopted, the contractor and the architect can determine the sequence of operation best calculated to keep down costs and can proceed without the complication of a hospital operation going on at the same time in the same space.

The active participation of the administrator, while important, is not necessary in the construction of new facilities. It is, however, highly essential in a renovation or modernization program because he alone has the knowledge and understanding of the many interrelated factors involved, as well as

the power of decision and activation. The administrator is the key person. He alone can best decide the planned sequence that will produce effective results.

Sequence planning is concerned both with the priority order in which work is done, and the time factors involved. One must take into consideration the continuation of effective services to patients, the effect upon operating income and the cost of the project. It requires much careful thought. The administrator should get all the help he can from his assistants, department heads, board members, the medical staff, the architect and the contractor. Sequence planning is like planning a chess game with moves and countermoves, plans and alternative plans. Flexibility of movement must be maintained. This is the responsibility of the administrator. Whether he delegates his responsibility or not, he must be in control of all renovation activity. He must work closely with his architect and contractor, keeping in mind their problem as well as his.

NEED FOR MASTER PLAN

Renovation and modernization in an existing hospital is usually a slow process continuing over an extended period. The extent of the work often depends upon the money available at any given time. It usually does not proceed smoothly as does new construction. Work continues irregularly with alternate periods of activity. The only sound method of approach, therefore, is for the administrator to prepare in advance a detailed over-all plan for all the work to be covered, the alternate space to be used, the order sequence, and a tentative time table for the work. This master plan of operation should:

- Describe the ultimate goals to be achieved, with each part fitted into the coordinated whole in such a manner as to provide the best and most efficient service to patients and doctors within the limitations imposed by the existing structure and arrangement.
- Provide that the coordinate parts of the whole be planned separately so that each may be attained independently in some planned sequence until the whole program is completed. This not only assures that the work will proceed in an orderly way toward the ultimate goal but it enables one to proceed as finances are made available.
- State a priority order in which each of the units will be undertaken. By planning a priority sequence, the administrator can avoid unnecessary or costly moves. The administrator must use the advice and the help of his subordinates, but he alone must be responsible for finding and deciding upon the "alternate space" requirements, for determining the necessary moves, and for planning the sequences that will most effectively achieve the desired end result. This involves long and careful study of the area concerned, the functions to be performed, the motions and the movements of the people involved, and the final arrangements needed to produce better service with fewer motions and movements in the space available.

before

LABORATORY

(LEFT) The old laboratory at Trinity Lutheran Hospital left a lot to be desired in the way of space and modern equipment. (BELOW) The new laboratory has plenty of working space for all the technicians and fine modern equipment. Lighting is good and floors and walls are easy to keep clean.

after

SUMMARY

Alternate space is the key to opportunity in planning; effective utilization of space is the key to realization of opportunities. One minimizes losses of income or interruptions of essential services; the other guarantees efficient day-to-day operating results thereafter. Sequence planning is the guarantee of orderly accomplishment. ■

personnel changes

● **Samuel L. Aspis, M.D.,** has been appointed manager of Veterans Administration Hospital, Kansas City, Mo. He was formerly manager of the VA hospital at Poplar Bluffs, Mo.

● **Robert E. DeBacker,** has been appointed assistant administrator of St. Joseph's Hospital, Houston, Tex. He formerly served his administrative residency at Santa Rosa Hospital, San Antonio, Tex. Mr. DeBacker holds an A.B. degree in business administration from Creighton University, Omaha, Nebr., and a master's degree in hospital administration from St. Louis University.

● **Robert W. Carithers** (see Rogers item).

● **James M. Edwards** has been appointed administrator of Okmulgee (Okla.) City Hospital. He was formerly administrator of Leeds (Ala.) Hospital Inc. Mr. Edwards is a graduate of the Georgia School of Business, Atlanta, program in hospital administration.

● **Edward P. Farage** has been appointed administrator of Orthopaedic Hospital and Dispensary, Trenton, N.J. He was formerly business manager and assistant administrator at Lancaster-Fairfield Hospital, Lancaster, Ohio. Mr. Farage is a graduate of the Arizona State College.

● **Richard Feldman** has been appointed administrative assistant and internal auditor of Beth Israel Hospital, New York City, succeeding Moses Baskin. He formerly served his administrative residency at Sinai Hospital, Detroit. Mr. Feldman is a graduate of the Columbia University program in hospital administration.

● **Leon Felson** has been appointed administrator of Kansas City (Mo.) General Hospital No. 1. He had been assistant director of Menorah Medical Center, also in Kansas City. Mr. Felson has a master's degree from Northwestern University, Chicago.

● **Gordon K. Flom** has been appointed assistant administrator of West Allis (Wis.) Memorial Hospital, on completing his administrative residency at St. Luke's Hospital, Milwaukee. He formerly served as regional administrator with Lutheran Hospitals and Homes Society, Fargo, N.D., for the eastern Montana and Dakotas area. Mr. Flom has a B.A. degree from Concordia College, Moorhead, Minn., and a master's degree in hospital administration from the University of Minnesota, Minneapolis.

● **William D. Hilliard** has been appointed administrative assistant of Fairview Park Hospital, Cleveland. He was formerly administrative resident at that hospital. Mr. Hilliard holds a B.S. degree from William & Mary College, Williamsburg, Va., and is currently working toward his master's degree in hospital administration from Northwestern University, Chicago.

● **Warner Jenkins** has been appointed assistant administrator of Alhambra (Calif.) Community Hospital, a newly created position. Mr. Jenkins was formerly managing editor of the *Alhambra Post-Advocate.*

● **George D. Mensah** has been appointed acting administrator of Liberian Government Hospital, Monrovia, Liberia, West Africa. Mr. Mensah was formerly acting administrator of Congo Town Hospital, and administrative assistant Public Health Central Office.

● **Clarence W. Miller** has been appointed administrator of Lake Wales (Fla.) Hospital succeeding **R. T. Stevenson, M.D.,** who has retired. Mr. Miller has been assistant administrator of the hospital. He is a graduate of the U.S. Navy School of hospital administration.

● **John Mote** (see Rogers item).

● **Bryan A. Rogers** has been appointed associate director of Methodist Hospital, Indianapolis. He succeeded **Robert W. Carithers** who resigned to assume a position with Booz, Allen and Hamilton as management consultant in the area of institutional services. Mr. Rogers was formerly administrative assistant at Methodist Hospital. He is a graduate of the Washington University program in hospital administration. **John Mote,** personnel director at the hospital, became administrative assistant and personnel director.

● **John D. Rollins,** administrator of Ontonagon (Mich.) Memorial Hospital has resigned his position to accept an appointment from the United Presbyterian Church, USA, as an administrator of two 100-bed missionary hospitals in North India.

● **Richard E. Sawyer** has been appointed administrator of Frankford Hospital, Philadelphia. He was formerly administrator of American University Hospital in Beirut, Lebanon. Mr. Sawyer is a graduate of the Columbia University program in hospital administration.

● **William J. Schwabe** has been appointed assistant director in charge of personnel relations of Johns Hopkins Hospital, Baltimore. He was formerly employed in the personnel division of the city government of Philadelphia.

● **E. Gilbert Slatton** has been appointed administrator of Eugene Wuesthoff Memorial Hospital, Rockledge, Fla. He formerly held the position of administrative assistant and comptroller at Tampa (Fla.) General Hospital, and prior to that was employed by Tri-County Hospital, Ft. Oglethorpe, Ga., and Baroness Erlanger Hospital, Chattanooga, Tenn.

MR. SLATTON

● **Joseph B. Smolens** has been appointed administrative assistant of the Hospital for Joint Diseases, New York City, under a fellowship established by Mr. and Mrs. Frederick Brown. Mr. Smolens previously served as administrative resident at Lebanon Hospital, New York City. He holds B.S. and M.A. degrees from New York University and an M.S. degree in hospital ad-

(Continued on page 94)

8 second magic in I.V. set-ups with the Cutter Saftisystem "28"™†

remove metal seal and disc

plug set into center of stopper with a quick thrust

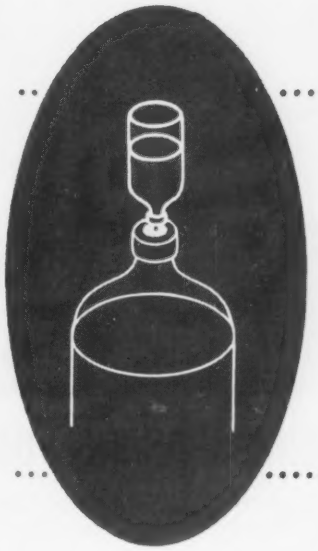
quickly invert bottle to visually check for vacuum and to automatically establish fluid level in drip chamber; clear tubing of air and infuse

†Patent Pending

ADDING MEDICATION IS EASIER AND MORE CONVENIENT

SAFTIFLASK® "28"™

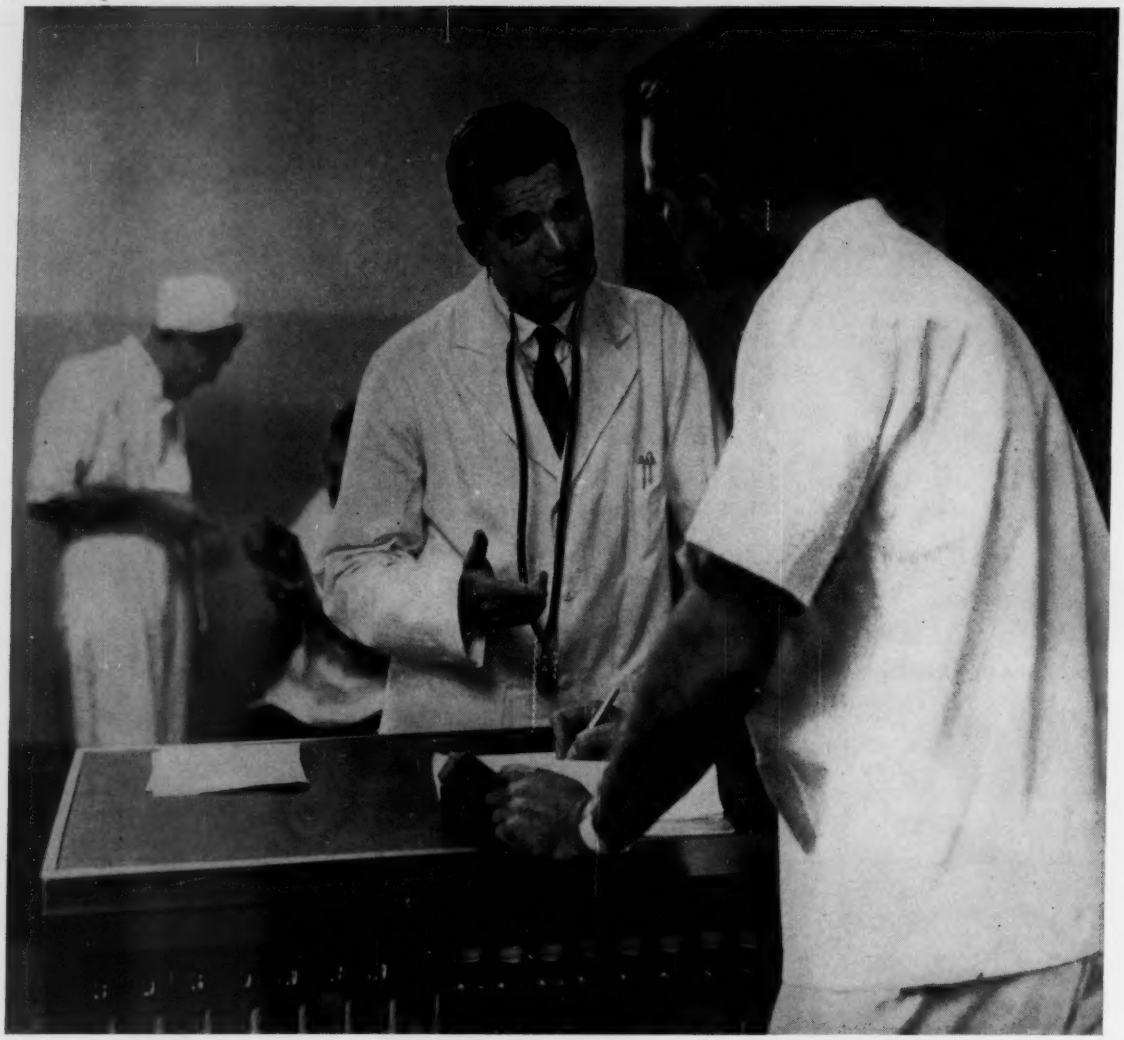
Add liquid medication with syringe.



Add liquid medication from a special additive vial with spike.

Add liquid medication by attaching syringe luer hub to air-inlet opening of Saftiset.

CUTTER LABORATORIES • Berkeley, California



"YES...I HAVE SPECIAL REASONS FOR SPECIFYING BUFFERIN"

There are a lot of reasons why so many physicians specify Bufferin. For instance, it's *better tolerated* than plain aspirin—many times better tolerated according to one recent study[1] of 236 patients. Therefore, it's the choice when high-dosage or long-term salicylate therapy is indicated. And Bufferin *contains no sodium* —so it's ideal for effective pain relief when the patient's on a low-salt or salt-free diet.

Bufferin makes work easier for the hospital staff too: no stomach upsets to waste nursing time—the fast onset of action means fewer of those "why don't I feel better yet" calls.

And the new 1,000 tablet hospital size bottle of Bufferin means that you can now economically stock this fine analgesic for general hospital and out-patient use. Be sure it's available in your pharmacy.

Each Bufferin tablet combines 5 grains of aspirin with Di-Alminate (Bristol-Myers' name for the exclusive combination of the antacids aluminum glycinate and magnesium carbonate).

1. Sher, D. B.: Aspirin and APC Irritation of the Stomach, Scientific Exhibit, World Congress of Gastroenterology; Washington, D.C., May, 1958.

BUFFERIN® 1,000's save money · save space · save time

ANOTHER FINE PRODUCT OF BRISTOL-MYERS

TUBERCULOCIDAL PROPERTIES OF FOUR HOSPITAL DISINFECTANTS

by EDWARD E. VICHER, Ph.D. and MILAN V. NOVAK, M.D.

Feeling that hospital disinfectants should be effective against the tubercle bacillus as well as other bacteria, the authors tested four of the newer disinfectant formulations to assay this quality. They conclude that the synthetic phenol formulations are particularly, and rapidly, effective against the tubercle bacillus.

A DISINFECTANT for hospital use should be effective against all pathogenic microorganisms including the tubercle bacillus. We have attempted to evaluate the antitubercular activity of four of the newer disinfectant formulations. Since there is no generally accepted

Edward E. Vicher, Ph.D., is associate professor of microbiology, and Milan V. Novak, M.D., is professor and head of the department of microbiology, University of Illinois, Chicago.

table 1

AGENT	CONCENTRATION	EXPOSURE TIME (Min.)	EXPERIMENT NUMBER	RESULTS OF CULTURE* NUMBER				RESULTS OF GUINEA PIG INOCULATION** NUMBER			
				1	2	3	4	1	2	3	4
Synthetic phenol formulation No. 1 (Staphene, Vestal Laboratories) *Active Ingredients:* Potassium p-tertiary amylphenate, soap, isopropanol, potassium o-phenyl phenate, potassium o-benzyl p-chlorophenate, tetra sodium ethylene diamine tetra acetate, sodium xylene sulfonate. Inert Ingredients: 78.85%	1% aqueous solution of commercial product	1	1	3	4			(−)	(−)		
			2			0	0			(−) Smear −	(−) Smear −
		5	1	0	0			(−)	(−)		
			2			0	0			(−) Smear −	(−) Smear −
		10	1	0	0			(−)	(−)		
			2			Not	done			Not	done
		15	1	0	0			(−)	(−)		
			2			0	0			(−) Smear −	(−) Smear −
		30	1	0	0			(−)	(−)		
			2			Not	done			Not	done
Control (water added)		30	1	20	22			(+)	(+)		
			2			Confluent growth				(+) Smear +	(+) Smear +

* *Expressed in number of colonies of Mycobacterium tuberculosis growing on the Lowenstein-Jensen slant.*

** *(+) indicates presence of macroscopic tubercles in liver, spleen and/or mesenteric nodes.*
(−) indicates absence of macroscopic tubercles in liver, spleen and/or mesenteric nodes.

method of assaying this property, a technique was devised which approximates the conditions met with in the practical use of such an agent.

By pooling several samples from patients with active tuberculosis, 200 ml. of sputum were collected. Of this quantity, 100 ml. were concentrated by treatment with Hanks' solution.* The washed sedimented concentrate was put into a sterile 250 ml. Erlenmeyer flask containing glass beads. This was set aside.

The remaining 100 ml. of sputum were autoclaved at 15 pounds pressure for 30 minutes. Two slants of Lowenstein-Jensen medium, containing a confluent growth of two new strains of *Mycobacterium tuberculosis* (from active cases), were washed with this autoclaved sputum into the 250 ml. Erlenmeyer flask. After a thorough shaking of the contents with the glass beads, the resulting suspension contained 30 to 50 or more bacilli per microscopic field at 1000X magnification; 0.5 ml. of this was put into a number of sterile 50 ml. Erlenmeyer flasks and distributed evenly over the bottom of each flask. The flasks were then placed in a dessicator and the contents were dried in vacuo over sulfuric acid for 48 hours. This produced a heavy, viscid mucoid film on the bottom of each flask. A sufficient number of flasks to complete the study were prepared.

*Hank's solution: sodium hydroxide, 4 per cent; potassium alum, 0.2 per cent; bromthymol blue, 0.002 per cent in aqueous solution.

TESTING TECHNIQUES

The following technique was used in testing the synthetic phenol formulations.† With each, 5.0 ml. of the dilution of the disinfectant were added to a prepared flask and the flask and its contents were rotated gently for the exposure time, after which the contents were aseptically transferred to a flask containing 10 ml. of Hanks' solution and 190 ml. of sterile distilled water to effect immediate dilution (and inactivation) of the agent. This also broke up clumps of tubercle bacilli still encased in mucus. After 30 minutes incubation at 37° C., the contents of the flask were neutralized by adding 2.5 N hydrochloric acid, drop by drop, until the color of the indicator denoted approximate neutrality. The organisms were sedimented by centrifugation.

†Samples for testing were furnished by the manufacturers.

The sediment was resuspended in 1.0 ml. of sterile saline, and 0.1 ml. was seeded onto each of two Lowenstein-Jensen slants which were incubated at 37° C. for one month. The remaining saline suspension was divided equally and injected subcutaneously into the groins of two guinea pigs. (See Tables 1, 2, and 3)

In the testing of the iodine compound,† the technique was essentially the same, except that the iodine compound was inactivated at the end of the exposure period by the addition of 1.0 ml. of a sterile one per cent aqueous solution of sodium thiosulfate. (See Table 4)

Controls consisted of flasks to which were added only 5.0 ml. of sterile distilled water (untreated controls) and flasks to which were

table 2

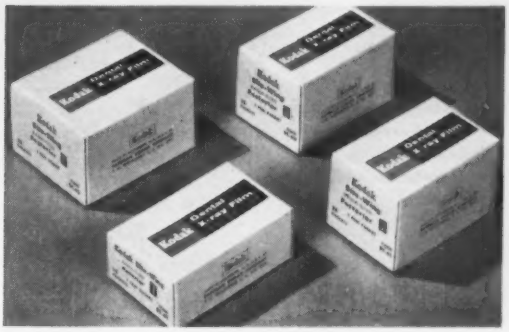
AGENT	CONCENTRATION	EXPOSURE TIME (Min.)	EXPERIMENT NUMBER	RESULTS OF CULTURE* NUMBER				RESULTS OF GUINEA PIG INOCULATION** NUMBER			
				1	2	3	4	1	2	3	4
Synthetic phenol formulation No. 2 (Amphyl, Lehn and Fink Products Corporation) *Active Ingredients:* Potassium ricinoleate, o-phenylphenol, p-tert. amylphenol and alcohol. Inert Ingredients: 30%	1% aqueous solution of commercial product	1	1	0	0			(−)	(−)		
			2			0	0			(−) Smear −	(−) Smear −
		5	1	0	0			(−)	(−)		
			2			0	0			(−) Smear −	(−) Smear −
		15	1	0	0			(−)	(−)		
			2			0	0			(−) Smear −	(−) Smear −
Control (water added)		15	1	Confluent growth				(+)	(+)		
			2			Confluent growth				(+) Smear +	(+) Smear +

* *Expressed in number of colonies of Mycobacterium tuberculosis growing on the Lowenstein-Jensen slant.*

** *(+) indicates presence of macroscopic tubercles in liver, spleen and/or mesenteric nodes.*
(−) indicates absence of macroscopic tubercles in liver, spleen and/or mesenteric nodes.

1. **September, 1955:** Announcement was made that Kodak Periapical Ultra-Speed Dental X-ray Film had been made *3 times faster* than the previous film.

2. **September, 1956:** *The doubling of the speed* of Kodak Radia-Tized Films—Periapical and Bite-Wing—was announced.



FASTER . . .
to reduce exposure
Kodak Medical and Dental X-ray Films have been greatly increased in speed

3. **July, 1957:** Kodak Royal Blue Medical X-ray Film—*the fastest Kodak medical x-ray film available*—was introduced. An increasing number of hospital x-ray departments are using Royal Blue for maximum radiographic information with minimum exposure.

4. **January, 1958:** New Kodak No-Screen Medical X-ray Film made available. *Speed increased 50 percent.*

5. **February, 1958:** Kodak Photoflure Medical X-ray Film, Green Sensitive, 35mm and 70mm rolls, *made twice as fast.*

See illustrated price list "Kodak X-ray Materials" for further details. Your dealer carries a full stock of Kodak x-ray products. Phone or write him about your needs. You can be sure of prompt service, as well as technical help.

Kodak
TRADE MARK

EASTMAN KODAK COMPANY, *Medical Division*, Rochester 4, N.Y.

table 3

AGENT	CONCENTRATION	EXPOSURE TIME (Min.)	EXPERIMENT NUMBER	RESULTS OF CULTURE* NUMBER				RESULTS OF GUINEA PIG INOCULATION** NUMBER			
				1	2	3	4	1	2	3	4
Synthetic phenol formulation No. 3 (O-syl, Lehn and Fink Products Corporation) *Active Ingredients:* Potassium ricinoleate, Orthodihydroxydiphenyl and Alcohol. Inert Ingredients: 55%	1% aqueous solution of commercial product	1	1	10-30	10-30			(+)	(+)		
			2			0	3			(+) Smear +	(+) Smear +
		5	1	0	0			(−)	(−)		
			2			0	0			(−) Smear −	(−) Smear −
		10	1	0	0			Not done			
			2			Not done				Not done	
		15	1	0	0			(−)	(−)		
			2			0	0			(−) Smear −	(−) Smear −
		30	1	0	0			(−)	(−)		
			2			0	0			(−) Smear −	(−) Smear −
Control (water added)		30	1	Confluent growth				(+)	(+)		
			2			Confluent growth				(+) Smear +	(+) Smear+

* *Expressed in number of colonies of Mycobacterium tuberculosis growing on the Lowenstein-Jensen slant.*
** *(+) indicates presence of macroscopic tubercles in liver, spleen and/or mesenteric nodes.*
(−) indicates absence of macroscopic tubercles in liver, spleen and/or mesenteric nodes.

added only 5.0 ml. of sterile distilled water and 1.0 ml. of a sterile sodium thiosulfate solution.

The guinea pigs were autopsied after eight weeks. They were declared positive or negative (infected or uninfected) upon findings from gross examination of spleen, liver and mesenteric nodes and/or from results of examination of stained impression smears prepared from these tissues.

In the first series of experiments performed (experiment 1 in Tables 1-4), impression smears were not prepared of the tissues of the animals; in the second series of experiments performed (experiment 2 in Tables 1-4), impression smears were prepared and examined.

The results of both series of experiments are shown in the accompanying tables.

CONCLUSIONS

1. The synthetic phenol formulations studied are effective tuberculocidal agents in these dilutions and under these conditions.

2. The iodophor formulation studied is an effective tuberculocidal agent in the dilution employed and under the conditions of this test.

3. Employing these specific dilutions, the synthetic phenol formulations exhibited very rapid tuberculocidal activity, effectively killing tubercle bacilli in one minute under the conditions of this testing procedure. ■

NOTES AND COMMENT

Use of sterilizing gas subject of study

Since many materials cannot be sterilized by heat, sterilization by gas is a possible alternative. Various mixtures of ethylene oxide with different gases and vapors have been found effective under different conditions of time, temperature, pressure and humidity. But, though many observations on this technique have now been published, particularly in the United

States, its assessment is complicated by the wide range of variable factors, as well as by the different bacteria and methods used for testing its efficacy.

Investigations in England of the possibility of sterilizing a heart-lung apparatus with ethylene oxide are reported in the May 2, 1959, issue of *The Lancet*. This machine has a cover of acrylic material (and some of the surfaces in contact with the extracorporeal circulation are also made of this), while polyvinyl chloride tubing and rubber also form parts of the apparatus. Preliminary tests were made under conditions which would have practical application on a large scale, the article states.

Testing disclosed two possible disadvantages of sterilization by ethylene oxide. First, solution of ethylene oxide from vapor can occur in rubber, and slow release of the gas into the circulation could possibly produce an undesirable concentration of ethylene glycol in the blood—even though the heart-lung machine is flushed with warm glucose saline before use—according to the investigators. Second, the possibility of a deleterious effect of ethylene oxide on different materials is important and requires further study. ■

table 4

AGENT	CONCENTRATION	EXPOSURE TIME (Min.)	EXPERIMENT NUMBER	RESULTS OF CULTURE* NUMBER				RESULTS OF GUINEA PIG INOCULATION** NUMBER			
				1	2	3	4	1	2	3	4
Iodophor formulation (Wescodyne, West Disinfecting Company) *Active Ingredients:* Polyethoxy polypropoxy ethanol-iodine complex, Nonyl phenyl ether of polyethylene glycol-iodine complex, hydrogen chloride. Inert Ingredients: 84.4%	75 parts per million (prepared by adding 4.5 ml. of commercial product to 995.5 ml. sterile distilled water.)	1	1	27	7			(+)	(+)		
			2			0	3			(+) Smear +	(+) Smear +
		5	1	3	3			(+)	(+)		
			2			9	0			(+) Smear +	(−) Smear −
		10	1	0	3			Not done.			
			2			Not done				Not done	
		15	1	0	0			(−)	(−)		
			2			0	0			(−) Smear −	(−) Smear −
		30	1	0	0			(−)	(−)		
			2			0	0			(−) Smear −	(−) Smear −
Control (water added)		30	1	50	20			(+)	(+)		
			2			50	30			(+) Smear +	(+) Smear +
Control (1% solution sodium thiosulfate, aqueous)		30	1	50	22			(+)	(+)		
			2			Confluent growth				(+) Smear +	(+) Smear +

* *Expressed in number of colonies of Mycobacterium tuberculosis growing on the Lowenstein-Jensen slant.*

** *(+) indicates presence of macroscopic tubercles in liver, spleen and/or mesenteric nodes.*
(−) indicates absence of macroscopic tubercles in liver, spleen and/or mesenteric nodes.

book reviews

Nursing evaluation

also:
Resource for evaluation
Insurance publication list
Profile of rehabilitation

SELF APPRAISAL GUIDE FOR HOSPITAL NURSING SERVICES. Mary Kelly Mullane. Detroit, Detroit and Tri-County League for Nursing, 1959. 29 pp. $2.

This self-appraisal guide is based on a research study in which eight nursing administration criteria—organization, planning, appraisal of service, conservation of energy and material, reporting, staff, purpose and budget—were tested and their association with excellence in nursing service administration demonstrated. The items under each criterion are clear, definitive statements of activities and appear to cover the major functions of nursing service administration. When checked "yes", or "no", or "in part", according to the degree to which each is observed, a clear identification of the strengths and weaknesses of the administrative practices should result.

The scoring method and records of plans for improvement will be welcomed by many, although they may seem elementary to the most sophisticated.

Self-evaluation guides are not new, but this is the first guide known to this reviewer that is specifically for nursing service. It should, therefore, make a valuable contribution to self-improvement programs wherever there is a real desire to increase the effectiveness of a service. Its value will be enhanced by the degree to which all personnel in nursing service administration participate in the appraisal.—MARY E. BRACKETT, R.N., *associate director of nursing service, Hartford Hospital, Hartford, Conn.*

Resource for evaluation

MEASUREMENT AND EVALUATION OF ORGANIZATIONAL PERFORMANCE; AN ANNOTATED BIBLIOGRAPHY. Paul Wasserman. Ithaca, N.Y., Cornell University, 1959. 110 pp. $3.75.

Mr. Wasserman has drawn together some of the best articles and books on measurement and evaluation of organizational performance since 1945. He has given a short, factual description of each of these published works without injecting a personal opinion. He has defined measurement and evaluation as:

1. Definition of the goals of the organization, functional unit, or individual position;
2. Determination of the acceptable levels of goal achievements, i.e., standards of performance;
3. Selection of the system to be used in measuring performance;
4. Application of the measurement system to performance;
5. Comparison of the results of measurement of performance with the previously established standards;
6. Determination of the significance of any difference between the results of the measurement of performance and the established standards of performance in order to modify the value-producing process or the standards.

The bibliography is divided into four sections. The first is measurement and evaluation in a general and theoretical manner. The material in the second section is concerned with measurement of the total enterprise, both of business organizations and nonbusiness organizations. The third is measurement of functional units within organizations. These are measurements of such divisions as accounting, advertising, personnel, production and purchasing. The fourth is the measurement of individual performance within the functioning units. This covers three phases: General and theoretical material, evaluation of executive performance, and techniques for measuring the individual effort.

The indexes are by author and title, and are clearly and concisely written so that the reader can find the material with a minimum of effort. This is the type of bibliography that administrators should have at their fingertips. Such a bibliography is an excellent resource for obtaining material on measuring and evaluating the performance of an organization.

—JACK OWEN

Insurance publication list

The Health Insurance Institute has recently published a pamphlet which draws together lists of books, annual publications and periodicals in the field of health insurance. In addition, it has chapters dealing with literature on general insurance, gerontology, social security and other data pertinent to research in the field. One section is devoted to the first known listing of national organizations having a relationship to the task of financing medical care costs.

The publication, entitled *A List of Worthwhile Health Insurance Books*, is available upon request from the Health Insurance Institute, 488 Madison Avenue, New York 22, N.Y.

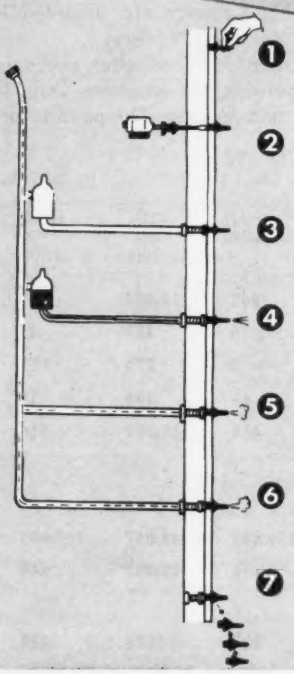
Profile of rehabilitation

REHABILITATION CENTERS TODAY. Henry Redkey. Washington, Government Printing Office, 1959. 231 pp. $1 (Rehabilitation Service Series no. 490)

This volume was originally begun as a revision of a book published in 1953 by the National Society for Crippled Children and Adults called *Rehabilitation Centers in the United States.* In response to a general feeling of need for more detailed information about rehabilitation centers, the Conference of Rehabilitation Centers, with the aid and support of the Office of Vocational Rehabilita-

(Continued on page 105)

clean 40 needles per minute with the Knight Needle Cleaner



Exclusive Knight System of Pressure Cleaning Positively Loosens and Removes All Soil from Needles

No other needle cleaner of any type cleans so thoroughly, positively and as fast. The improved Knight needle cleaner is automatic—with capacity limited only by operator speed, and an average unskilled operator can clean 2100 needles per hour.

Here's how the Knight Hypodermic needle cleaner works:

1 LOADING POSITION. To load, insert needle into groove on control side nearest you. 2 COTTON SWAB. Needle is brought to motor driven cotton swab which wipes out needle hub. 3 DETERGENT JET. Needle moves to detergent position. Detergent jet forces cleaning solution through needle under pressure. 4 DISTILLED WATER JET. Needle moves to distilled water position where jet forces water through needle to wash out detergent. 5 AIR JET. Needle moves to air position where air jet blows out the water. 6 AIR JET. Needle moves to second air jet which dries the needle. 7 AUTOMATIC RELEASE. Cleaned needle released automatically to curved soft plastic receiving tray. Also available with cotton swab operation between the air jets.

See the Knight needle cleaner demonstrated at booth 2216 of the American Hospital Association Show.

TECHNICAL EQUIPMENT CORP.

917 Acoma Street **Denver 4, Colorado**

QUICK WAY TO MEASURE LAUNDRY OUTPUT PER MANHOUR

by F. G. BRUESCH and JAMES L. BLACKBURN

The Harper Hospital laundry has devised a quick method of figuring production per employee, the authors state. Use of this method increased production last year by 8.8 per cent over the previous year, according to their figures.

IT IS considered good laundry practice to compile figures showing production achieved by or expected of operators of various laundry machines such as washers, flatwork ironers, hot air tumblers, presses, etc. But gathering such information requires a certain amount of clerical detail, for which every laundry manager does not have time.

Seeking a relatively quick way to acquaint management with what was going on in our laundry, we devised a rather simple method. We had been weighing all our linen for years because we consider this a "must" to insure correct size loads for washers and extractors. We also find weighing necessary to achieve uniform quality of work and prevent wastage of supplies.

F. G. Bruesch is administrative assistant and James L. Blackburn is laundry manager, Harper Hospital, Detroit.

FINDING NET WORKING DAYS

Since the weight of laundry done during each two-week pay period was readily available, it was only necessary to set up two forms to get the other information needed —correct number of days laundry employees worked and average production per employee per day.

Figure 1 shows two sample pay periods of two weeks each and yearly totals for 1957 and 1958. Deducting the days allowed for paid sick leave, paid holidays and paid vacation, gives net working days.

FINDING AVERAGE PRODUCTION

Dividing total weight of linen laundered in a two-week period by net working days gave the average pound production per employee per day (see Figure 2). All employees including the manager and his forelady are included in the total days worked.

During 1957 production averaged 217 pounds per employee day. In 1958 it averaged 236 pounds per

FIGURE 1

	1958				1957			
	PERIOD ENDING 12/13	PERIOD ENDING 12/27	TOTAL FOR YEAR	AVERAGE PER PERIOD	PERIOD ENDING 12/14	PERIOD ENDING 12/28	TOTAL FOR YEAR	AVERAGE PER PERIOD
Total payroll days	677	664	17,830	686	689	683	18,582	715
Vacation days	0	4	740	28	0	4	684	26
Paid sick days	10	22	297	12	7	2	275	11
Paid holidays	0	63	381	15	0	61	366	14
Net working days	667	575	16,412	631	682	616	17,257	664

FIGURE 2

	1958				1957			
Pounds of linen laundered	151,994	132,350	3,864,121	148,619	143,196	130,800	3,744,867	144,033
Net working days	667	575	16,412	631	682	616	17,257	664
Average pounds per employee per day	228	230	631	236	210	212	5638	217

employee per day. The increase in labor efficiency in 1958 over 1957 was 8.76 per cent. Dollar savings were approximately $6900. This does not take into consideration a 3.22 per cent increase in volume of linen handled. This increase in efficiency did not just happen, but was achieved by closely watching the quantity of linen received and the number of employees needed to obtain maximum production.

Harper Hospital allows all laundry employees a two-week vacation after one year and three weeks of vacation after five years. Since labor turnover in the laundry department is small, nearly everyone gets two or more weeks vacation. It is necessary to schedule vacations from May through October because work is light during this period. Scheduling vacations so that the right employee is available for the right job is no easy matter. To do this, the manager and his assistant must know the skills required for each job and which employees have those skills. An employee might be an excellent worker on the flatwork ironer but be a poor press operator.

In attempting to compare production figures with other hospital laundries, it is necessary to know how much and what type of work is done in each laundry. We include all wearing apparel, flatwork, tumbler work and everything else done in the laundry.

LAUNDRY FUNCTIONS

At Harper Hospital, the laundry handles all linen distribution. Four people do nothing else but sort and fold the operating and obstetrical linen for packs. In many hospitals this is done by the central supply department. The laundry mends old linen and marks new linen. In some hospitals mending is handled by members of the housekeeping staff. The laundry also dyes operating room linen and rags.

As a rule, hospitals are very lenient in their treatment of employees with long service records. Harper Hospital is no exception, for we, too, have a number of employees unable to produce as much as others because of age or physical incapacity. These factors show up in the average production figures.

EQUIPMENT ANOTHER FACTOR

Another factor affecting production is the number of labor saving devices installed in any laundry. At Harper Hospital we have a mechanical sheet folder, self-dumping washers with automatic formula control and monorail operation of the extractors.

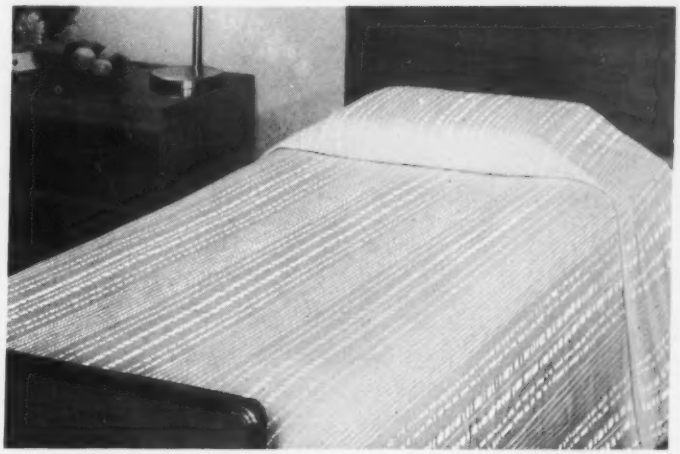
Another consideration is whether the laundry is equipped with enough machinery to operate efficiently when breakdowns occur. The time lost getting machinery back into operation is important, because the average hospital laundry seldom has excess equipment. It is wise to consider this when building a new hospital or remodeling an old one.

Perhaps this method of computing laundry production would not satisfy every hospital, but it does provide a means of comparison and is a stepping stone to more detailed production figures should they be desired. ■

'Know this rare Bird?'

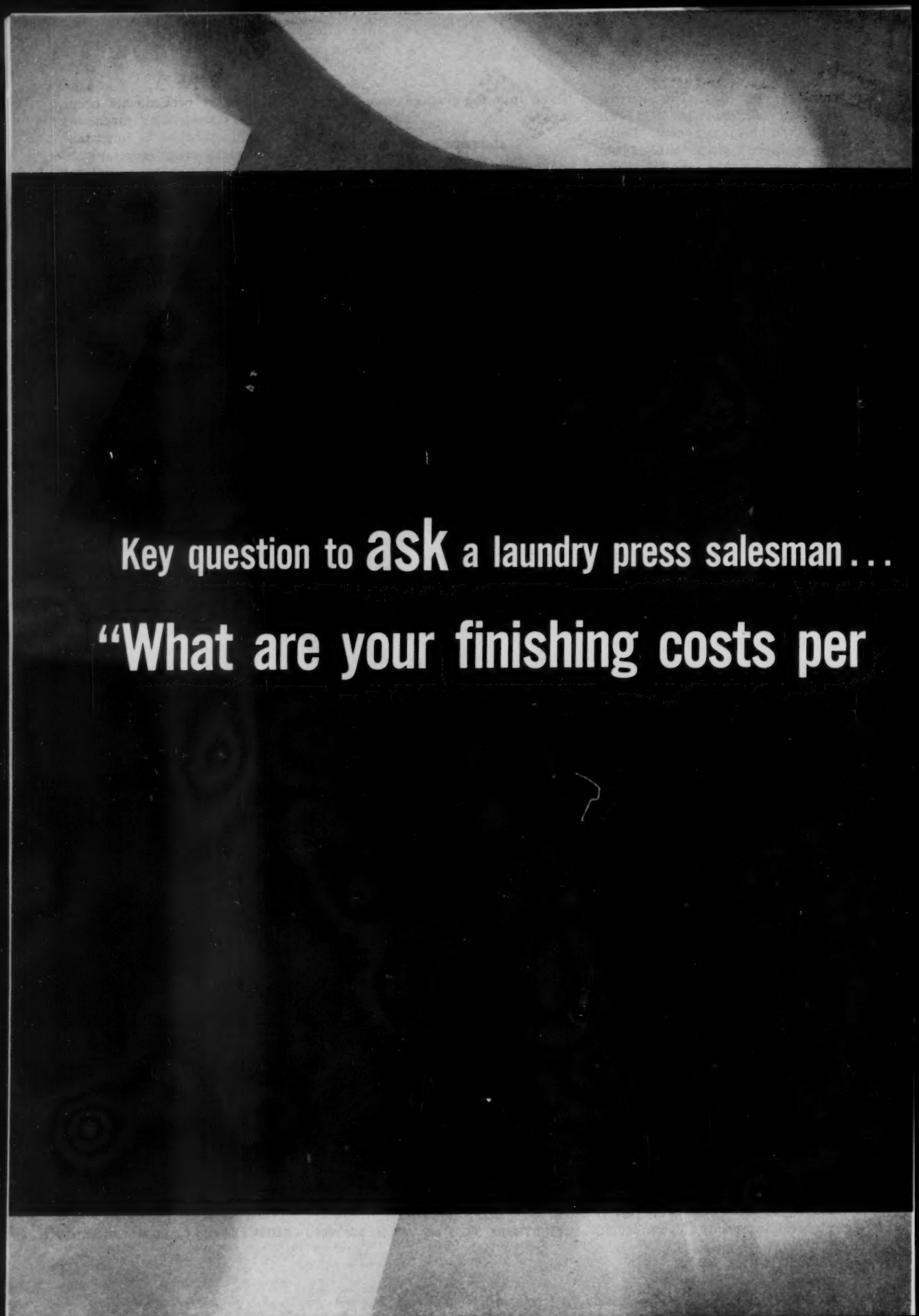
He's often seen "going it alone"... won't fly with the others. Won't take a tip from the wise birds who pick the best spots thru experience. He settles for a lot less *for only a little less!* Hospital buyers who know their way around feather their nests with Bates Ripplette. They know Ripplette is tough as ostrich hide —reinforced for hospital routine, ready for a lifetime of wear and washing. Second-best bedspreads just won't do for hospitals. They *always* buy the best—the one and only Bates Ripplette.

Bates

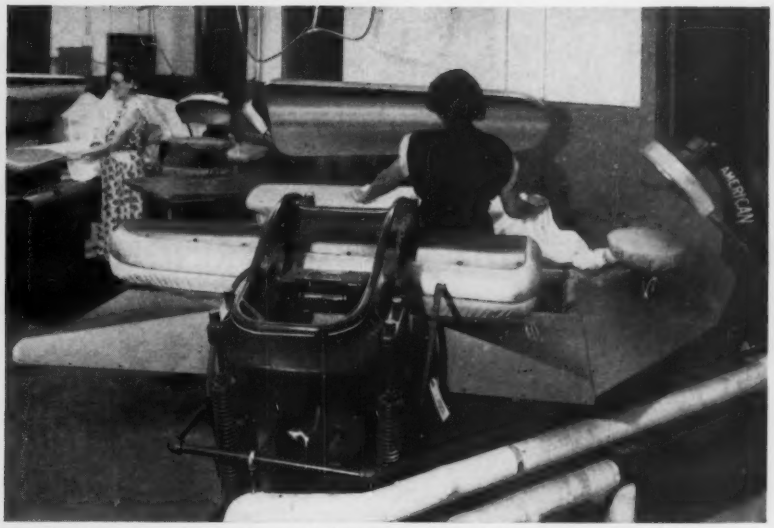


BATES RIPPLETTE The original hospital-tested bedspread with the reinforced ripple. No imitation can equal it for extended wear, easy washing. Sizes 72 x 90, 72 x 99, 72 x 108, 90 x 108. Also available in 63" and 81 inch widths. All White.
Call your Bates distributor or write:

BATES FABRICS, INC., 112 W. 34TH ST., NEW YORK 1 • BOSTON • CHICAGO • ATLANTA • LOS ANGELES


Key question to ask a laundry press salesman . . .
"What are your finishing costs per

hundred?"



At Flushing (N. Y.) Hospital and Dispensary these two units of Model 54½ Super-Zarmo and Model 106-A Super-Zarmoette Presses finish uniforms and other garments at the lowest possible cost per hundred pieces.

Your American salesman's answer is positive and direct. "Comparison tests prove our Model 54½ Super-Zarmo Apparel Press will save you an average of *90c or more per 100* on your apparel finishing costs!" And, he'll back up his answer with facts! This applies to every hospital laundry that finishes garments of any type. Here's why:

• Extra-large buck requires fewer press lays. • Unique shape of buck gives unlimited versatility. Accommodates a wide variety of garments, eliminating extra lays on other presses. • Powerful, unvarying *direct-upward pressure* quickly imparts a fine-quality finish to even the heaviest garments.

No other laundry press can match the Model 54½ Super-Zarmo for quality, speed and versatility.

For a sure way to lower *your* cost per hundred garments, call your nearby American representative. He'll gladly show you a Model 54½ Super-Zarmo Press Unit in action. Or, if you prefer, mail the coupon for complete information.

The American Laundry Machinery Company, Cincinnati 12, Ohio

You get more from

American

The American Laundry Machinery Company ALM-606
Cincinnati 12, Ohio

Please send Catalog AK 530-542 (54½) which tells how the Model 54½ Super-Zarmo Press will lower my finishing costs.

Name_____

Care of_____

Address_____

City_____ Zone____ State____

In Canada—The Canadian Laundry Machinery Company, Ltd., 47-93 Sterling Road, Toronto 3, Ontario

WHY ONE HOSPITAL SWITCHED TO DISPOSABLE SYRINGES AND NEEDLES

by STEVE J. SOLTIS

A hospital administrator describes a three-month controlled study of disposable syringes and needles conducted in his hospital. He outlines the methods used in the study, compares the cost of disposables with that of reusables, and staff and patient reactions to the use of disposable needles and syringes.

BECKLEY MEMORIAL Hospital is a 200-bed general hospital with a very active ambulatory patient clinic. Most of our patients are coal miners and their dependents. Since Beckley Memorial is one of a network of ten hospitals, supplies are standardized and are purchased through the Miners Memorial Hospital Association central purchasing office. Standardization does not preclude experimentation with new products or new methods. If and when the staff of a hospital wishes to experiment, the findings are shared with the other hospitals.

STUDY OF DISPOSABLES

This study was made to determine whether or not use of disposables would do the following: (1) save dollars, (2) save time and increase staff efficiency, and (3) increase patient satisfaction. The study was conducted during three periods of three weeks each, with the full cooperation of the nursing service, central sterile supply, general stores and clinical laboratories personnel.

During the first three weeks, detailed records were kept of the number of injections given, the number of needles and 2-cc, 5-cc, and 10-cc syringes processed in central sterile supply and the amount of time required for processing. A reasonable estimate of the number of injections per year, based on daily records during this control period, would be 92,000.

During this period, we found that 58 per cent of the syringes and 62 per cent of the needles were returned unused to central sterile supply for reprocessing. This per cent of items returned unused was due to at least two factors: the hospital complement is set up to take care of peak loads; and, since the multiple container and single wrap method is used, it was insisted that syringes and needles should be reprocessed after 12 hours to assure sterility.

TEST USE OF DISPOSABLES

Next came the trial use of disposable syringes and needles throughout the hospital in two three-week stages. For the first, disposable syringes and needles were used exclusively in the ambulatory patient clinic, clinical laboratory, operating suite and on one patient floor. Central sterile supply kept a record of the amount of time required for loading carts and for distribution to selected areas. The nursing service recorded the time required to prepare the injection, to travel to the patient, to give the injection and to chart the medication. At the end of three weeks, these areas reverted to reusable glass syringes and needles. The remaining two patient floors and the obstetrical suite used disposables the following three weeks. All areas of the hospital, therefore, had sufficient experience to compare methods and to make an adequate evaluation.

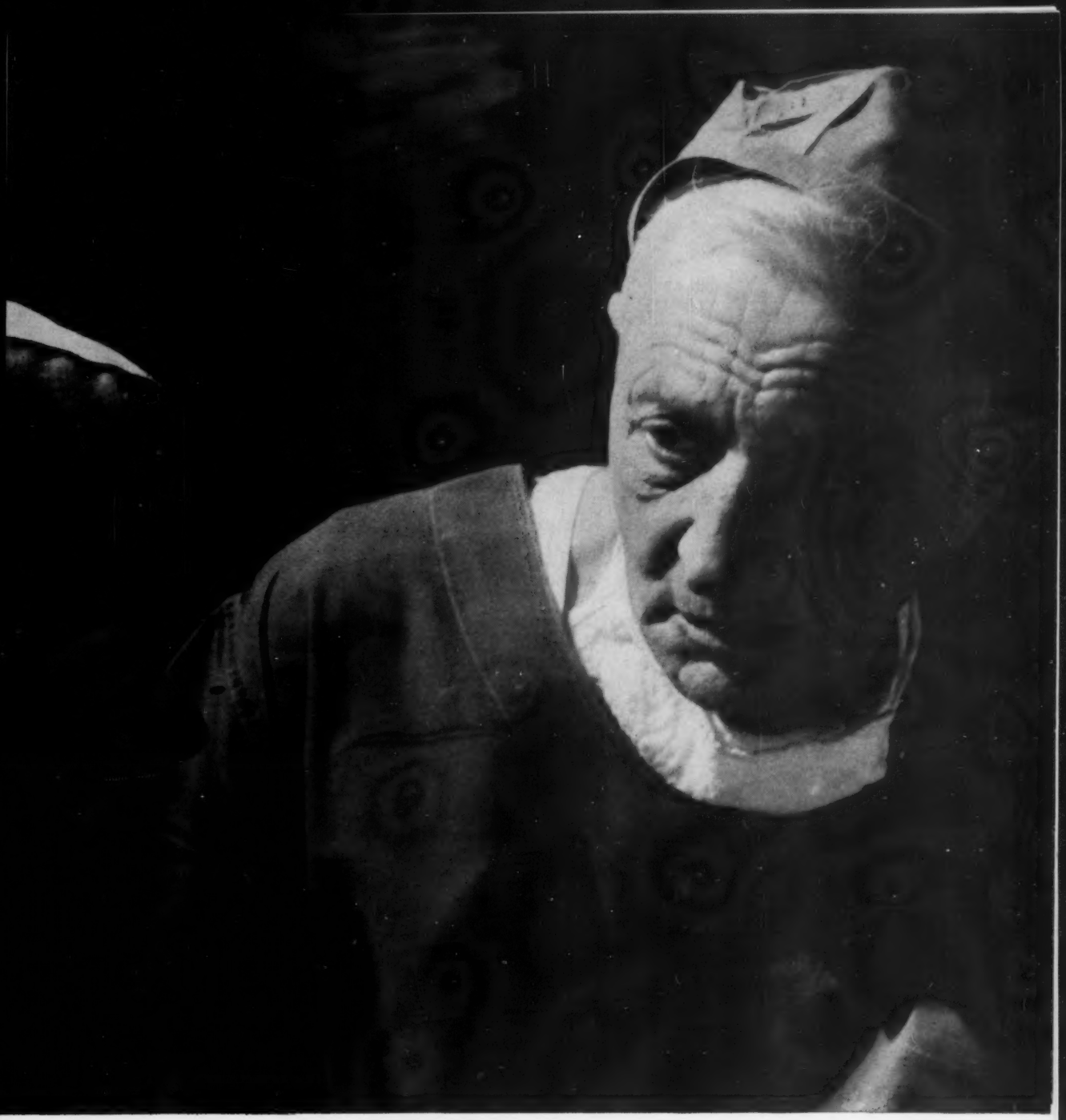
COST COMPARISONS

During the trial use of disposables, a thorough review was made of costs—including labor; supplies (cotton, applicators, gauze, detergent, envelopes and tape); replacement of syringes and needles averaged over a three-year period; and maintenance and depreciation of the syringe washer, needle washer, needle sharpener, and syringe and needle containers. These costs, projected on an annual basis, indicated the raw cost per injection in the accompanying table.

REUSABLE SYRINGES AND NEEDLES	COST
Supplies per injection (syringes, needles, cotton, applicators, envelopes, etc.)	6.9¢
Central sterile supply (labor for collecting, sorting, washing preparing, assembling, loading and unloading sterilizers, distributing)	6.9¢
Nursing service (labor for preparing injection at nurses' station, travel time to patient, injection procedure, disassembling and rinsing, and charting medication)	15.1
Total cost	28.9

(Continued on page 74)

Steve J. Soltis is the administrator of the Beckley Memorial Hospital, Miners Memorial Hospital Association, Beckley, West Virginia.



IS THERE TOO MUCH TALK ABOUT RESISTANT STAPH AND TOO LITTLE ACTION IN PREVENTING INFECTION?

Medical and hospital trade literature, the last few years, has been filled with articles and advertisements about resistant Staph. The problem has been serious. But we feel that resistant Staph is not the basic problem. It is the danger to patients from **all kinds** of infection. A workable patient-safety program is not an easy one to maintain.

A giant step toward the solution of this infection problem can be taken, we feel, by recreating the old-fashioned attitudes toward cleanliness in **all** hospital personnel in **every** department.

These old-fashioned attitudes, combined with modern, efficient aseptic products, can help you prevent cross infection. On the next four pages we hope you will read about a few of the Huntington products which will help you maintain aseptic techniques.

Where research leads to better products... **HUNTINGTON**

HUNTINGTON LABORATORIES • HUNTINGTON, INDIANA • Philadelphia 35, Pennsylvania • *In Canada:* Toronto 2, Ontario

DISPOSABLE SYRINGES AND NEEDLES	COST
Syringe and needle unit (based on estimated yearly requirement of approximately 62,050 2-cc's, 15,330 5-cc's and 14,600 10-cc's)	12.1c
Central sterile supply (labor for loading cart and distributing)	3.0c
Nursing service (labor for preparing injection at nurses' station, travel time to patient, injection procedure, breaking syringe at luer tip, depositing needle in barrel and securing with plunger, and charting medication)	13.0c
Total cost	25.4c

We arrived at $3686 per year as the amount that could be saved by using disposable syringes and needles. The actual dollar saving was $727 per year. This amount did not include nursing time saved, at two cents per injection, nor the time—approximately two hours a day—of a medical technologist. On an annual basis, the value of time saved amounted to $2959. These comparative cost figures were arrived at by estimating the cost of 2-cc, 5-cc and 10-cc disposable syringes and needles required for a one-year period and the annual cost of the reusable glass system, including supplies, materials, depreciation, maintenance and the salaries of one full-time and one part-time person.

Greater savings should be possible in the future as these products become more competitive and as other sizes and types—20-cc, 30-cc, 50-cc insulin and tuberculin—become available.

ADVANTAGES OF DISPOSABLES

The high standard of sterility of the disposable is even more impressive than the dollar saving. The element of human error, possible in the many stages of reprocessing reusables, is eliminated.

Staff efficiency increases with continuing use of disposables, especially on the part of nurses and medical technologists. They no longer waste time trying to free frozen syringe plungers, to clear plugged, dull or barbed needles, or to tighten loose-fitting barrels. They do not have to contend with the annoyance and delay of broken or cracked syringes.

Patients have not only not complained when disposable syringes and needles were used, but many have also made such comments as, "I could hardly feel the needle."

DISADVANTAGES

At the time of the writing of this paper, disposable syringes and needles only have been used at Beckley Memorial Hospital for almost three months. There have been some minor complaints: (1) plunger action was difficult to control on some 5-cc and 10-cc syringes, and (2) needles popped off a few when medication was being administered. The first difficulty was met by rotating the plunger up and down to distribute the silicone evenly throughout the barrel. The second was overcome by instructing the nurses to check the units for needle tightness as soon as they removed the syringe from the package. Needles on units recently received from the manufacturer have been more tightly fitted to the syringes.

This nine weeks' study with careful controls and accurate records, has convinced us that disposables meet our needs more adequately than reusable syringes and needles. ■

NOTES AND COMMENT

Copying machine jobs multiply, hospital finds

When the Arlington (Va.) Community Hospital installed an office copying machine with which to duplicate certain reports and schedules, it was found that the machine not only saved time and money in doing the jobs for which it was purchased, but also that additional uses were constantly suggested.

Some of the original purposes of the machine were the following:

The daily operating room schedule, formerly prepared by a typist in the admitting office, was not ready for distribution until 5 p.m., too late in the day to give physicians, nurses, and anesthetists adequate notice. Two typings of the report were necessary to obtain sufficient number of copies. Now, one master copy of the operating schedule is prepared and enough extra copies made on the copying machine. The entire project takes less than half an hour, compared with three hours formerly.

The daily admission and discharge record was previously typed as many as five times to prepare the required number of copies. One master report is now typed and individual copies made on the copying machine in approximately four seconds, eliminating tedious proofreading and valuable time lost in excess typing.

Since about 40 per cent of all patients ask for duplicates of their accounts for personal bookkeeping, insurance and tax purposes, the business office uses the machine for making extra copies from the master card.

Some of the additional uses of the unit which the hospital discovered were in the administrative office:

Copies of the monthly minutes of board of trustees meetings are made from one master copy and distributed in minimum time.

Monthly call schedules for staff physicians and resident staff members are made up in master copy form and copies sent out as services are determined. Changes can be added and new copies made at any time. In the past, the schedule was delayed until the entire list had been determined and a stencil cut.

Questionnaires, of which only one copy is usually received by the hospital, are copied on the machine and sent to the various departments concerned. They are returned, tallied and then the original questionnaire is typed out, saving time and eliminating confusion.

Copies of medical transcripts are prepared by the record room without extensive typing and sent immediately to physicians.

Copies of insurance reports, purchase orders, business forms, routine correspondence, etc., can be made for filing or for further distribution.

Copies of diagrams of complicated hospital equipment were recently copied for use in the standard nursing procedure manual. Detailed drawings and charts can be copied on the machine just as easily as written or typed items. ■

CLEAN AND DESTROY BACTERIA IN ONE STEP WITH NEW DI-CROBE GERMICIDAL CLEANER

For the first time, a soapless anionic detergent and a phenolic germicide have been successfully combined. Di-Crobe Germicidal Cleaner cleans, disinfects and deodorizes most hospital surfaces in one easy step.

Di-Crobe is bactericidal under use dilutions. Quick-cleaning action and germicidal power remain stable, even when exposed to heavy soil. Hard or cold water may be used without fear of creating a soap film or of destroying conductivity.

Di-Crobe kills a broad spectrum of microbes, including resistant Staph, at very high dilutions. When not rinsed, Di-Crobe leaves a lasting antibacterial blanket. It is also non-toxic and non-irritating. See our representative, the Man Behind the Huntington Drum, for full details and send for the Di-Crobe Germicidal Cleaner Research Bulletin to get annotated test results.

Where research leads to better products... **HUNTINGTON**

HUNTINGTON LABORATORIES • HUNTINGTON, INDIANA • Philadelphia 35, Pennsylvania • *In Canada:* Toronto 2, Ontario

equipment and supply review

New product descriptions included in this section are condensed from reports furnished by manufacturers and distributors. Descriptions are included here for informational purposes and such inclusion does not constitute endorsement by the American Hospital Association.

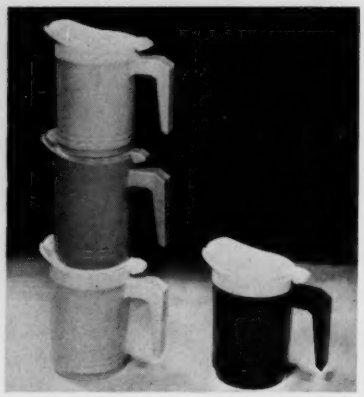
Portable window platform (16D-1)

Manufacturer's description: Portable platform for window washers, painters and other maintenance men fits all

windows up to 7 ft. 6 in. wide. The platform rests on the outside sill and is firmly held by a telescoping steel tube on the inside. It folds compactly for carrying. It weighs 32 lbs. and is of sturdy steel construction with hardwood platform. *Albert W. Pendergast Safety Equipment Company, Dept. H13, 6988 Tulip St., Philadelphia 35.*

Insulated server (16D-2)

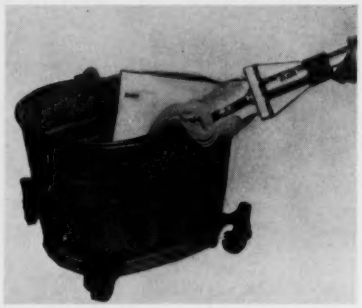
Manufacturer's description: This 10-oz. server has built-in insulation to prevent the escape of heat or cold. Made of a stain-resistant material the thermos is easy to clean, will withstand boiling water, and is virtually unbreakable because no



glass is used. The bottom and top of the thermos are designed for easy stacking and storage. *Service Ideas, Inc., Dept. H12, 26 South Sixth St., Minneapolis 2, Minn.*

Mop handle (16D-3)

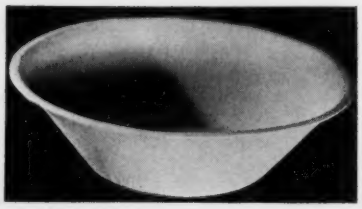
Manufacturer's description: With a few twists of a plastic dial, this mop handle with "roto-gripper" allows a tongued key to slide out so as to fit, grip, and double lock into a receiving metal mophead cap. The interlocking of the mop holder and the mophead takes only seconds. This device permits the mophead



to come closer with the floor, and eliminates scratching or marring of baseboards, walls and furniture. *Du-Mor Products Company, Dept. H13, 1260 West 4th St., Cleveland, 13.*

Disposable wash and emesis basin (16D-4)

Manufacturer's description: This presterilized, white, waterproof, disposable paper wash and emesis basin is noiseless, firm, and won't wilt. The 2½ in. deep bowl has a top diame-



▶ If you wish to have your name sent direct to the manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 840 North Lake Shore Drive, Chicago 11, Illinois.

PRODUCT NEWS

_____Portable window platform (16D-1)
_____Insulated server (16D-2)
_____Mop handle (16D-3)
_____Disposable wash and emesis basin (16D-4)
_____Pharmaceutical mixer (16D-5)
_____Anesthetist's stool (16D-6)
_____Molded carafe (16D-7)
_____Silent TV paging system (16D-8)
_____Automatic light control (16D-9)
_____Postoperative drainage unit (16D-10)
_____Folding arm chair (16D-11)
_____Slanted-slot bed sign (16D-12)
_____Patient scale (16D-13)
_____Accessory cart (16D-14)

PRODUCT LITERATURE

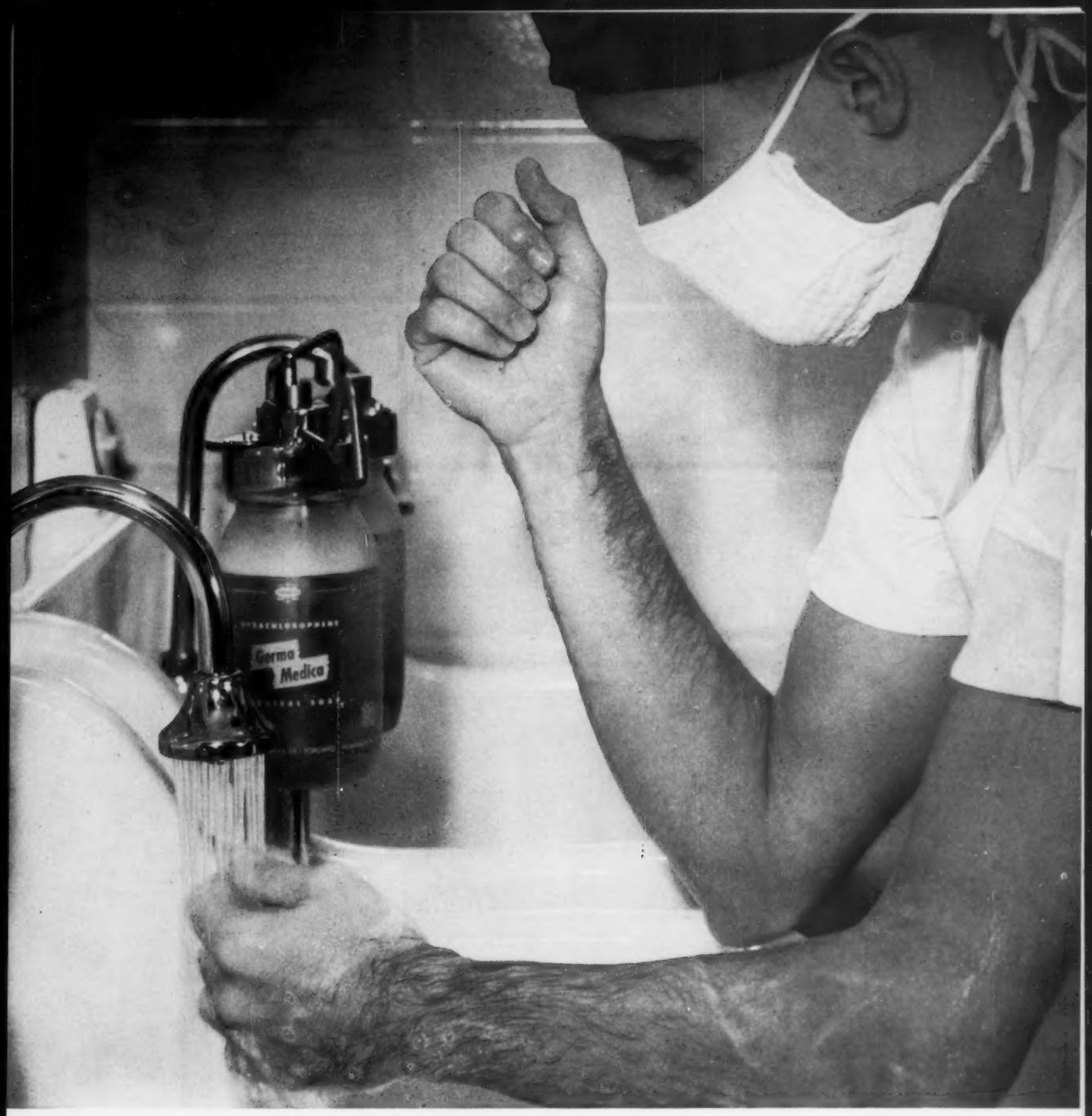
_____Salad recipe booklet (16DL-1)
_____Medical warning labels (16DL-2)
_____Water conditioners (16DL-3)
_____Liquid oxygen (16DL-4)
_____Waste disposal system (16DL-5)
_____Air conditioners (16DL-6)
_____Blood-testing procedures (16DL-7)
_____Ultrasonic cleaning tips (16DL-8)
_____Business forms and systems (16DL-9)

NAME and TITLE_____

HOSPITAL_____

ADDRESS_____

(Please type or print in pencil)



GERMA-MEDICA® LEAVES HANDS SURGICALLY CLEAN WITH HEXACHLOROPHENE WITHOUT THAT "DRIED-OUT" FEELING . . .

Germa-Medica Liquid Surgical Soap with Hexachlorophene has had a long history of being the favored surgical soap for the surgeons' prep in many hospitals. It not only cleans hands to a degree approaching sterility, with routine, regular use, but it also helps keep hands smooth and soft. Germa-Medica includes imported olive oil and other oils which increase its emollient effect on the skin.

Germa-Medica with Hexachlorophene is low cost and mild . . . making it an ideal antiseptic soap for use at **all** hospital stations.

A special preservative in Germa-Medica is highly active against all kinds of bacteria, including Gram negative microorganisms. This preservative protects Germa-Medica against contamination that can result in handling, from the shipping containers to the dispenser jars, with a wide margin of safety. See our representative, the Man Behind the Huntington Drum, for full details and send for the Germa-Medica Liquid Surgical Soap with Hexachlorophene Research Bulletin to get annotated test results.

Where research leads to better products . . . **HUNTINGTON**

HUNTINGTON LABORATORIES • HUNTINGTON, INDIANA • Philadelphia 35, Pennsylvania • *In Canada:* Toronto 2, Ontario

ter of 9 in. and a bottom diameter of 4½ in., with a capacity of 48 ozs. It can be used as a disposable bed pan, or as a disposal receptacle in the operating and birth rooms, and in the lab. *Busse Hospital Products, Dept. H15, 64 East 8th St., New York 3, N.Y.*

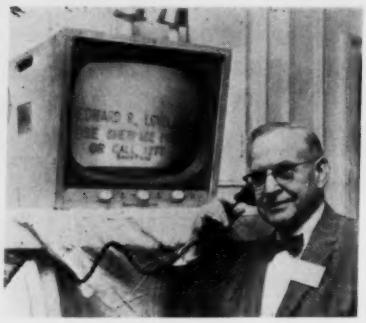
Pharmaceutical mixer (16D-5)
Manufacturer's description: This mixing unit can process dry materials and liquids of light to heavy viscosity. The all-purpose motor can be used continuously without overheating. Different attachments permit 14

operations. The user can mill, granulate, mix, grind, extract, shake, vibrate, knead, agitate, coat, press, fill, or mold as required. The attachments can be attached to or removed from the motor drive quickly and easily. *Chemical and Pharmaceutical Industry Co., Inc., Dept. H13, 90 West Broadway, New York 7.*

Anesthetist's stool (16D-6)
Manufacturer's description: This new anesthetist's stool has conductive casters and a conductive cover over a thick rubber pad. The stool is adjustable from 21 in. to 31 in. and the seat revolves freely. The base is finished in brilliant chrome. *F. & F. Koenigkramer Co., Dept. H10, 96 Caldwell Dr., Cincinnati 16, O.*

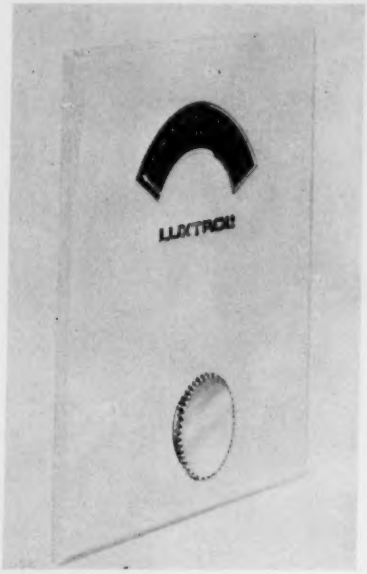
Molded carafe (16D-7)
Manufacturer's description: This carafe of unbreakable high-density polyethylene material can withstand temperature extremes. It can be autoclaved, and, after sterilization, it can be partially filled with water and frozen in a refrigerator. It is molded in one piece so there are no seams to crack or to collect bacteria. The material is nontoxic and resists all chemicals. The top of the carafe lifts off and it becomes a drinking tumbler. The carafe holds one quart of liquid. *The General Tire & Rubber Company, Dept. H13, Bolta Products Div., Lawrence, Mass.*

Silent TV paging system (16D-8)
Manufacturers description: Television-type paging system consists of a series of television receivers linked with a message center in a closed



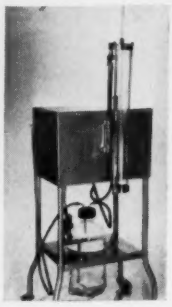
circuit. At the message center, names of doctors being paged are placed on a continuous turntable which revolves in front of a television camera. Names of doctors being paged are flashed on the television screens for approximately 7-seconds. The physician picks up a phone wired into the side of the television receiver and has his message read to him. *Giantview Television Network, Dept. H13, 901 Livernois, Ferndale 20, Mich.*

Automatic light control (16D-9)
Manufacturer's description: Light control system "measures" daylight and balances it with electric light to assure a constant level of room illumination. The nerve center of the system is a dial pre-set to maintain the desired level of room light. A photoelectric scanner is mounted where it can best monitor the area to measure the level of combined daylight and artificial light. It constantly relays this information to a signal system which activates motor-driven variable transformers either to brighten or



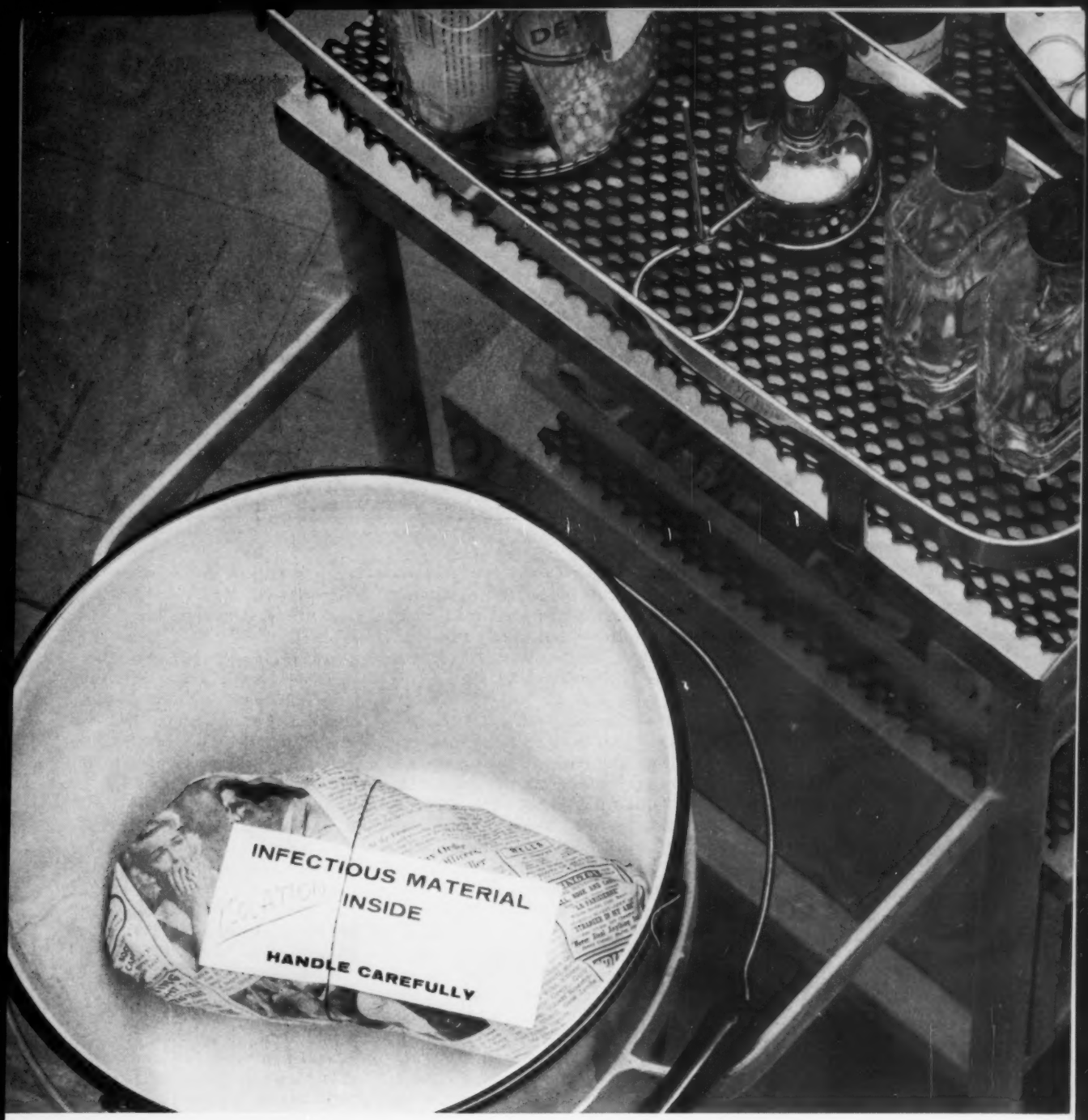
dim the lights. *The Superior Electric Company, Dept. H13, 83 Laurel, Bristol, Conn.*

Postoperative drainage unit (16D-10)
Manufacturer's description: Post-operative drainage unit covers all fields of suction drainage (open, closed, intermittent and thoracic). The outer tube functions as an underwater sterile seal. The inner tube functions as the vacuum control tube and is calibrated from 0 to 12 in. of water. This gives the same effect as a common three-bottle system.



The pump output is variable, giving a wide range of rate of flow from the slowest required to the maximum. *C. M. Sorensen Co., Dept. H11, 50-19 47th Ave., Woodside 77, L.I., N.Y.*

Folding arm chair (16D-11)
Manufacturer's description: New arm chair folds to a neat, flat three inches. The arms fold in one motion with the rest of the chair. The chair has a steel frame with



DECONTAMINATE NEARLY ALL SURFACES WITH SAN PHENO® X . . . A HIGHLY BACTERICIDAL GERMICIDE

With pathogenic microorganisms lurking everywhere, it doesn't pay to take chances with anything less than the most effective germicide in hospitals today. This is why so many hospitals use San Pheno X Germicide for general purpose disinfecting. Its broad bacterial spectrum, ease of use, and economy make San Pheno X ideal for disinfecting walls, floors, furniture, equipment; for obstetrical preparation; and for many other uses. It is highly effective against resistant Staph.

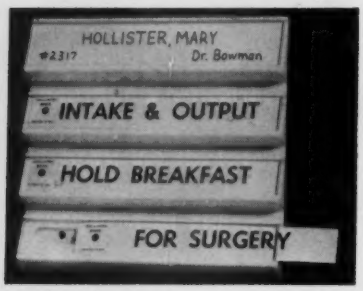
San Pheno X will not irritate or sensitize skin and will not stain or corrode metal when used as directed. It has no unpleasant "disinfectant" odor. See our representative, the Man Behind the Huntington Drum, for full details and send for the San Pheno X Germicide Research Bulletins, including brochure, "Laboratory Reports on San Pheno X Germicide."

Where research leads to better products . . . **HUNTINGTON**

HUNTINGTON LABORATORIES • HUNTINGTON, INDIANA • Philadelphia 35, Pennsylvania • *In Canada:* Toronto 2, Ontario

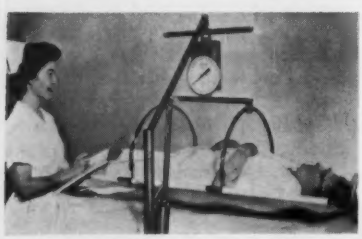
naugahyde, nylon or grospoint upholstery material over foam rubber. A wide selection of colors is available. *Clarin Mfg. Co., Dept. H12, 4640 W. Harrison St., Chicago 44.*

Slanted-slot bed sign (16D-12)
Manufacturer's description: This slanted-slot bed sign may be read with ease from any level, whether mounted low on a footboard or



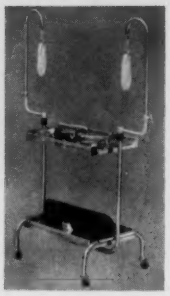
high on a wall or door. The sign attracts staff attention to important orders for patient care and helps eliminate error. Plastic-coated reminder cards are available, with more than 120 standard wordings. Clear safety panels slide out so that the sign may be attached (screw holes are concealed underneath) and then locked in place to protect the cards. Made of shatter-resistant nylon plastic, the sign can be wiped clean with a damp cloth and is available in a variety of sizes. *Hollister, Inc., Dept. H15, 833 North Orleans St., Chicago 10, Ill.*

Patient scale (16D-13)
Manufacturer's description: Graduated in



half pounds, with a capacity of 300 pounds, this scale will weigh patients in either a seated or supine position. The scale can be quickly attached to lifting devices manufactured by the same company for any weighing operation. This simplifies weighing any patient, particularly those confined to bed. *Porto-Lift Manufacturing Co., Dept. H16, Roscommon, Mich.*

Accessory cart (16D-14)
Manufacturer's description: This accessory cart permits storing operating table accessories in one convenient location. The trays are easily removed and can be sterilized. The stainless steel frame is mounted on 2-in. conductive casters which provide protection from electrostatic hazards. *Shampaine Company, Dept. H16, 1920 S. Jefferson, St. Louis 4.*



product literature

SEE COUPON, PAGE 76

Salad recipe booklet (16DL-1)—Compact recipe booklet containing more than 70 new ideas and recipes for salads and salad dressings. *H. J. Heinz Co., Dept. HL16, P.O. Box 28, Pittsburgh 30, Pa.*

Medical warning labels (16DL-2)—The label is to be attached to the front of a patient's chart jacket. A heavy red border surrounds the words "drug sensitivity". Space is also provided to write the names of drugs that should not be used. The adhesive sticker requires no wetting. *Topflight Corporation, Dept. HL16, 160 E. Ninth Avenue, York, Pa.*

Water conditioners (16DL-3)—Booklet describing and picturing a new line of water conditioning units that provide completely automatic soft-conditioned water. *Water Refining Co., Dept. HL16, 104 Manhattan Street, Middletown, Ohio.*

Liquid oxygen (16DL-4)—Brochure describing a liquid oxygen customer station, how it works and the various benefits of liquid oxygen. *Ohio Chemical & Surgical Equipment Co., Dept. HL16, 1400 East Washington Ave., Madison 10, Wis.*

Waste disposal system (16DL-5)—Brochure describes a waste disposal system that chews up garbage and paper into finely ground, compacted pulp (far less bulky then the original waste) and renders it odorless without the use of chemicals. *Wandel Machine Company, Dept. HL16, Pomeroy, Pa.*

Air conditioners (16DL-6)—Brochure describes a line of packaged air conditioners. It also illustrates design and construction features of the units. *American-Standard Industrial Division, Dept. HL16, Detroit 32.*

Blood-testing procedures (16DL-7)—A 48-page booklet completely describes recognized blood-testing techniques and procedures, including typing, cross-matching and antibody testing. *Certified Blood Donor Service, Dept. HL16, 146-16 Hillside Ave., Jamaica 35, N.Y.*

Ultrasonic cleaning tips (16DL-8)—Booklet includes a simplified explanation of the basic principles of ultrasonics, a brief description of the generating equipment and transducers required for ultrasonic cleaning, and a discussion of proven applications. *Circo Ultrasonic Corporation, Dept. HL16, 51 Terminal Ave., Clark, N.J.*

Business forms and systems (16DL-9)—Brochures containing miniature sample forms designed to simplify and speed office procedures and cut overhead costs. These include custom-tailored payroll checks, purchase orders, invoices, etc. *The Reynolds & Reynolds Company, Dept. HL16, 800 Germantown St., Dayton 1, Ohio.*

GET HANDS AS GERM FREE AS HANDS CAN BE WITH HEXA-GERM

ANTISEPTIC SKIN DETERGENT WITH HEXACHLOROPHENE

Statistics tell us that, in about 30% of all operations, surgical gloves break or are cut. Surgically clean hands are vital. This is one of the reasons so many hospitals use Hexa-Germ—a white, viscous, liquid antiseptic skin detergent with 3% hexachlorophene.

Tests show that routine use of Hexa-Germ degerms skin to a degree approaching sterility. It has also been proved effective in preventing staphylococcal skin infections in the newborn nursery. Because Hexa-Germ is blended with lanolin and petrolatum, it replaces the natural emollients lost through prolonged cleansing.

A special preservative in Hexa-Germ is highly active against all kinds of bacteria, including Gram negative microorganisms. This preservative protects Hexa-Germ against contamination that can result in handling, from the shipping containers to the dispenser jars, with a wide margin of safety. See our representative, the Man Behind the Huntington Drum, for full details and send for the Hexa-Germ Research Bulletin to get annotated test results.

Where research leads to better products... **HUNTINGTON**

HUNTINGTON LABORATORIES • HUNTINGTON, INDIANA • Philadelphia 35, Pennsylvania • *In Canada:* Toronto 2, Ontario

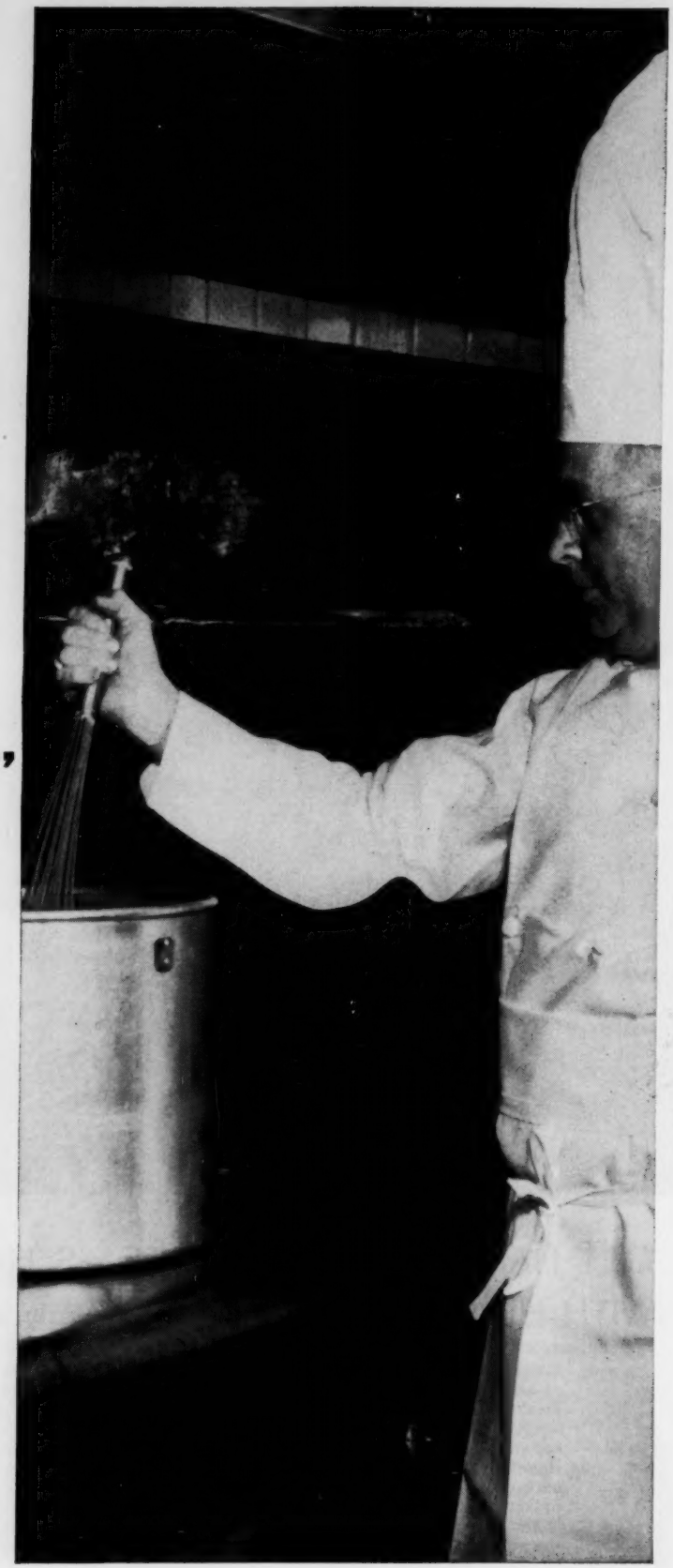
"We like the dependable, flexible service our GAS equipment gives"

Lasell Junior College
Auburndale, Massachusetts

"We've always used Gas, and we've always been more than happy with the results," say Chef E. K. Turner and Dietitian Miss Elizabeth Smith of Lasell Junior College. Gas helps the chef prepare the tasty, appetizing food students write home about because Gas provides close control over cooking and baking. Gas is also clean, fast and dependable, with minimum maintenance.

The modern Gas equipment Lasell Junior College uses includes 5 Vulcan ranges, 2 Vulcan broilers, 2 Blodgett ovens, 3 Pitco fryers, 2 griddles, a baker's stove and a Gas proofing closet.

For information on how Gas can help you prepare quality food, call your Gas Company commercial specialist. He'll be glad to discuss the economies and outstanding results Gas and modern Gas equipment provide. *American Gas Association.*

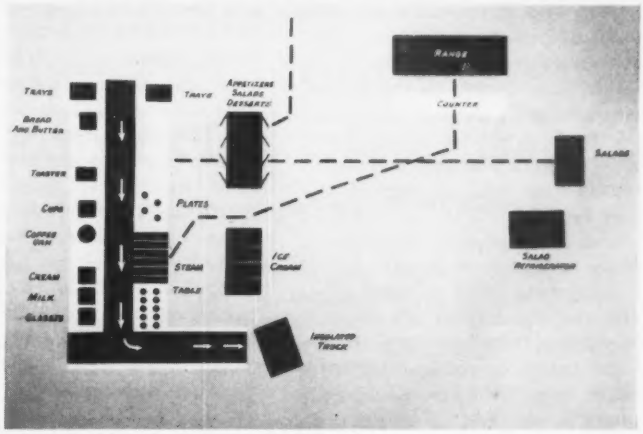


GOOD FOOD— a public relations plus

by MRS. ELIZABETH E. HALLECK

Good food well prepared and attractively served is an effective selling point for any hospital, the author states. She outlines five basic steps used at Greenwich (Conn.) Hospital for achieving good food and food service to patients and personnel.

PATIENT at Greenwich (Conn.) Hospital expresses pleasure at appearance of noon-day tray just delivered by a dietary aide. A selective menu is offered.



FLOW CHART and diagram of centralized tray service operation in main kitchen at Greenwich (Conn.) Hospital. Note location of serving stations (hot and cold food sections) in relation to cooking or refrigeration areas.

FOOD SERVED to a patient is an important part in the hospital's day-to-day public relations program. In order to be an effective public relations tool for the hospital, however, the food served must be of the best quality; that is, it must be good food well prepared and attractively served at the proper temperature.

How does the dietitian produce this first-class food? At Greenwich (Conn.) Hospital we feel that there are basically five steps involved. They are:

1. Introduction to the patient.
2. Selective cycle menu.
3. Purchasing of good quality food.
4. Careful preparation of all menu items.
5. Appearance and temperature of the food.

INTRODUCTION TO THE PATIENT

Patients at Greenwich Hospital are invited to "climb aboard the good health express" and travel to their destination of good health by way of the essential basic foods. "Conductor" of the train is the therapeutic dietitian who calls at his bedside and leaves a timetable with a few words of cheer and suggestion.

The timetable is a six-page folder, entitled *Climb Aboard the Good Health Express.* It guides the patient in making menu selections and includes information on good nutrition. The first page, called "Take Off News", tells the patient he has the opportunity of selecting his menu and how he is to indicate his food choices. On the

Mrs. Elizabeth E. Halleck is chief dietitian at the Greenwich (Conn.) Hospital.

second page, the "Red Cap" says, "Choo-se" daily from seven basic foods in selecting meals. On the third page, the "hostess" suggests a balanced diet. The fourth page, "Stops Along the Way", describes the City of Protein, Vitamin Village, Mineral Hill, Watertown and the Twin Cities called Carbohydrates and Fats.

SELECTIVE CYCLE MENU

At Greenwich Hospital we use a three-week cycle menu. The cycle is changed with the four seasons of the year. Corrections and improvements are made after each cycle. The menus are flexible to allow for changes for holidays, fast days and special catering functions requiring extra baking or cooking. The same basic menu is used in the pay cafeteria with the addition of many standard items.

Our selective menus have been planned to suit the needs of most modified diets as well as to meet patients' preferences. Orange juice, therefore, is always on the breakfast menu with another fruit juice and fresh fruit in season. Soft cooked eggs are always offered at breakfast as well as eggs in another form.

Food for the selective menu is chosen so that there is no overload on equipment, such as baking beyond the capacity of the oven or overloading the steam table, the top of the range or refrigerator. Any one of these problems could ultimately lower food standards with resulting poor public relations for the hospital.

FOOD PURCHASING

Quality of food served is in large measure controlled by the quality purchased. At Greenwich Hospital we buy from well established and dependable companies. Before placing the initial order with a new company, we check with hospital dietitians in our area for references. We ask these questions: Does the company stand by verbal prices? Is there a delivery charge? Are orders always completely filled? Can delivery days be depended upon? Are specifications adhered to? Are credits given willingly?

New items are always tested before they are purchased. Reliable companies are happy to submit samples. A group consisting of dietitians, cooks and aides taste the product; if satisfactory, it is added to the menu in the pay cafeteria. If the menu item proves popular in the cafeteria, it is added to the patient's selective menu.

The dietary department works closely with the receiving department to be sure that the correct weight, quality of food received, time of delivery and specified brands are as ordered.

FOOD PREPARATION

Standardized recipes are developed to suit a predetermined taste. Employees are trained to carry out the dietitian's high standards in regard to food preparation and food service. The cooks are told to think of their cooking or finished product as being served to their own house guests. The cooks are told when a food item is unusually good and also when it is not up to standard. At conferences with dietitians and cooks, recipes are discussed with a view to improving them.

At Greenwich Hospital we make our own ice cream. A cafeteria counter girl spends five hours a week making 70 gallons of ice cream and sherbet. Because it is home-made, it is served in a home-made style. Each portion is prescooped into a fluted, colored paper baking cup and frozen. Served very hard on the patient's tray, the ice cream is the right consistency by the time the patient is ready to eat it.

At Greenwich Hospital it costs $1.16 per gallon to make the ice cream. Our raw food cost for the ice cream is $81.20 a week for 70 gallons. If we purchased it from a commercial company, our total food cost would be $1.90 per gallon or $133 per week. This represents a saving of $51.80 per week and $2694 per year. Deducting the cafeteria girl's salary of $338, Greenwich Hospital saves $2356 per year by making its own ice cream. Moreover, we feel home-made ice cream is better received by patients and helps to build good will for our hospital.

With only one pastry cook to provide the many and varied bakery items for the patients, personnel and special catering functions, we find it is advantageous to use cake, pie, bun, roll and even some cookie mixes. With the help of a pastry cook from the company from whom the mixes are purchased, our cook learns to use these products to their best advantage.

To prepare and serve food properly, it is necessary to have well trained employees. The problem is greatly simplified in a central tray service such as ours because dietitians and supervisors work closely with the employees and can more readily train them to do as many jobs as they are capable of learning. This makes the work more varied for the employee and also provides the department with numerous people who can replace or relieve one another.

By careful training we have been able to replace experienced personnel with less skilled ones and to upgrade certain positions. The vegetable preparation man has been replaced by a fourth cook. This employee, who was a diet aide, showed promise and interest in bettering himself. In his new position, he receives a higher salary for preparing vegetables, assists in cooking breakfast, and serves the entree on the conveyor belt.

Our night porter's job has been upgraded. He now takes care of the dining room, operates the dishwashing machine at the evening meal and supervises the late supper (10:45-11:15 p.m.) He makes sandwiches to order, serves desserts and beverages, and operates the cash register.

Just as Greenwich Hospital has grown in size, so has the amount of catering done by the dietary department. The cafeteria supervisor, who is interested in learning new things, has been trained to take charge of many of our catering affairs. Among the catered events is the personnel service award dinner held once a year in the dining room for personnel receiving pins for their service to the hospital. As we have no waiters or waitresses, a regular training program is in full swing for four weeks. Two hours a day are spent in training 12 high school boys to set, serve and clear the tables correctly. Each year the boys have done an excellent job serving the dinner.

APPEARANCE OF FOOD

The fifth step in serving quality

food and thereby building public relations is the appearance and temperature of the food served on the tray. The trays are assembled on a conveyor belt in the main kitchen (see diagram p. 83). The tray is set with a printed paper tray cover, folded napkin and silver. Sugar packets and napkin are held in place by the glass salt and pepper shakers. The china is a multi-colored floral pattern. Plastic-necked hottles are used for the hot and cold beverages.

The tray is examined by a food service supervisor. Not only does she check the tray against the selective menu sheet, but she also sees that dishes and silver are in proper place and that the entire tray reflects painstaking care.

After fulfilling these five basic steps, how do we determine whether or not our food service and the quality of our food are good? We learn from our dietitians who talk with patients, from patient opinion polls, complimentary notes jotted on menus, and from letters sent to us. The results, we are proud to say, show our food and food service is good.

At Greenwich Hospital our experience has shown that good public relations for the hospital is obtained in part through the use and service of high quality food. All patients look forward to their three meals a day. Some, unfortunately, have little else to look forward to during their hospitalization. In the department of dietetics, we feel that we can't let them down. ■

NOTES AND COMMENT

Seattle hospital features seafood, dessert recipes

Clam souffle and sole thermidor with almonds are two favorite seafood specialties of patients at Maynard Hospital in Seattle, reports Jean Ishida, chief dietitian.

Miss Ishida also reports that orange torte and cranberry crunch are among the dessert favorites with patients at the hospital.

Here are the recipes.

CLAM SOUFFLE
(24 servings)

½ c. plus 1 tbsp. butter
½ c. plus 1 tbsp. flour
1½ c. clam juice
1½ c. cream
2¼ c. minced clams
12 egg yolks
½ c. chopped parsley
Salt and pepper as needed
Nutmeg as needed
12 egg whites

1. Melt butter and blend in flour.
2. Mix clam juice and cream together and slowly add to first mixture, stirring constantly. Cook and stir until thickened.
3. Add minced clams, remove from range and cool slightly.
4. Beat egg yolks thoroughly and add to sauce.
5. Add chopped parsley; season with salt, pepper and nutmeg.
6. Beat egg whites until firm but not dry. Fold half into sauce thoroughly. Fold the remaining half in lightly.
7. Pour into buttered souffle dish. Bake in 375°F. oven for 30-35 minutes.

SOLE THERMIDOR WITH ALMONDS
(36 servings)

8 lbs. fillet of sole
Salt as needed

Here's ONE Reason Why "Dri-Heat" Keeps Food Hot... *better than any other serving system!*

Only "Dri-Heat" provides the complete protection shown in the cross-section above. No other system designed for centralized food service uses double-wall construction across the entire bottom surface and side wall.

This is especially important to you.

It means better insulation and heat-retention . . . no hot spots on the bottom to annoy diners . . . more uniform heat dissapation for better food protection.

Many other "Dri-Heat" exclusive features serve to save you money and improve your food service. Let us tell you about them soon. No obligation, of course. Write today.

"Dri-Heat"—the *complete* food system—serves you to serve your patients best.

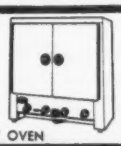
Stainless steel cover has special heat-trap design

Dri-Heat Hot Plate accommodates any standard china or plastic dish

Special alloy pellets can be used for heating or chilling food

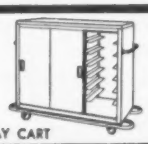
Fully insulated stainless steel base protects diner's hands. Double wall fully insulated—guaranteed not to come apart.

See us at Booth 2119 AHA Convention



PELLET OVEN

PELLET OVEN STAND



TRAY CART

Trade Mark Reg'd. Patented and others pending.

DRI-HEAT FOOD SYSTEM

DRI-HEAT FOOD SYSTEM, INC.
500 N. Dearborn St., Chicago 10, Illinois
In Canada: Dri-Heat Food System, Ltd., 1202 Yonge St., Toronto 7, Ontario

2 qts. scalded milk
1 c. butter
1 c. plus 2 tbsp. flour
1¼ tsp. dry mustard
⅛ tsp. cayenne
1 tsp. salt.
6 c. shredded processed American cheese
1 tsp. worcestershire sauce
1½ c. chopped, roasted unblanched almonds

1. Roll fillets; place in shallow baking dish and sprinkle with salt. Pour milk over fish. Bake in 350°F. oven for approximately 20 minutes.

2. Meanwhile, blend butter, flour, mustard, cayenne and salt.

3. Drain milk from fish and blend with butter-flour mixture. Cook and stir until mixture boils and is thickened. Add cheese and worcestershire sauce. Pour over fish fillets. Sprinkle with almonds. Bake 15 minutes longer.

CRANBERRY CRUNCH
(20 servings)

3 c. quick-cooking rolled oats
1½ c. sifted flour
3 c. brown sugar, firmly packed
1½ c. butter or margarine
3 (1 lb.) cans whole cranberry sauce

1. Mix rolled oats, flour and sugar together.

2. Cut in butter until mixture is crumbly.

3. Divide half of mixture between two, greased, 7½x11x2-inch baking pans. Pat firmly into place.

4. Cover the two lined pans with half of cranberry sauce. Top with remaining crumb mixture.

5. Bake at 375°F. for 35 minutes.

6. At service time, cut into squares and serve with whipped cream.

ORANGE TORTE
(28 servings)

8 oz. shortening
12 oz. brown sugar
2 eggs
12 oz. cake flour
2 tsp. baking powder
2 tsp. baking soda
2 c. rolled oats
1 pt. sour milk or buttermilk
2 c. raisins
2 medium-size oranges

1. Wash oranges. Quarter and remove seeds.

2. Grind oranges and raisins together.

3. Cream sugar and shortening.

4. Add eggs and continue beating.

5. Combine dry ingredients and add alternately with milk.

6. Add ground oranges and raisins last.

7. Pour into oiled sheet pan and bake at 350°F. for 50 minutes.

Fall Cycle Menu for the North-Northwest

THE 21-DAY selective fall cycle menu and market orders for perishables are designed for hospitals in the North-Northwest. These menus, which are to be used during September, October and November, feature foods popular in the northern and northwestern parts of the country.

The summer cycle menus, published in the April and May 1958 issues of this Journal, are for use during August. The Midwest and South-Southwest cycle menus were included in the April 1 and 16 issues, respectively. The May 1 and 16 issues featured cycle menus for the East and North-Northwest, respectively.

The menus in this issue are the final set in a four-part series of fall cycle menus published in this Journal. Fall cycle menus for the Midwest were included in the July 1 issue of **HOSPITALS**, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION. The South-Southwest fall cycle menus were published in the July 16 issue of the Journal. The East menus were included in the August 1 issue.

In planning the menus, careful consideration has been given to keeping the menu and food production operation simple for the smaller hospital. A moderate to low cost food budget was used.

This cycle menu features a choice of entree, vegetable, salad and dessert on the noon and night menus. Two cereals and two fruits are offered on the breakfast menu.

Since one of the choices offered is designed for use on modified diets, these menus can be used for both normal and modified diets. The letter (F) following certain items on the menu indicates that this item is to be served on the full or normal diets, while those labeled (S) are for the soft and other modified diets. Where the letters (FS) appear, the menu item can be served on both the full and soft diets.

The market order for perishables, which accompanies each week's menu, lists the meats, seafood, poultry, and fresh and frozen fruits and vegetables that a 50-bed hospital will need to produce the menu. The amounts are computed on the basis of serving 100 patient and personnel meals at breakfast, 125 at noon and 100 at night. By using a multiple of 50, larger hospitals can easily arrive at their market orders.

The market order includes all portion-ready meats, oven-ready roasts, portion-ready seafood, eviscerated poultry and other pre-prepared items.

An added feature of this menu service is the standard storeroom inventory, a list of supplies that a 50-bed hospital should have in the storeroom at the beginning of each 21-day cycle. The items included are cereals and farinaceous products, canned fish, canned fruits and fruit juices, dried fruits and vegetables, jellies, cake and pudding mixes, pickles, canned soups and canned vegetables.

The standard is available upon request from the American Hospital Association, 840 North Lake Shore Drive, Chicago 11, Ill.

NEW LOW PRICES

FLEX-STRAW FOR QUALITY
PRECISION CORRUGATION
UNMATCHED FLEXIBILITY

ON THE ORIGINAL FLEX-STRAW®

- Proved in a decade of hospital use.
- Extra-strength paper . . . ¼ inch diameter.
- For hot liquids, coated with high temperature resistant micro-crystalline wax.
- Hospital surveys prove FLEX-STRAWS cost less.
- Added protection plus economy!

VISIT OUR EXHIBIT
AHA 61st annual meeting
Aug. 24-27, 1959

CANADIAN DISTRIBUTOR:
Ingram & Bell, Ltd.
Toronto, Montreal,
Winnipeg, Calgary,
Vancouver

FLEX-STRAW CO., Int'l.
2040 BROADWAY, SANTA MONICA, CALIF.

CONTACT YOUR FLEX-STRAW DISTRIBUTOR FOR CURRENT QUOTATION

1st WEEK NORTH-NORTHWEST SELECTIVE FALL CYCLE MENU

(MENUS TO BE USED DURING SEPTEMBER, OCTOBER AND NOVEMBER)

—prepared by Jean Ishida, chief dietitian, Maynard Hospital, Seattle, Wash.

	breakfast	noon	night
monday	Stewed Apricots **or** Pineapple-Grapefruit Juice Cornmeal Mush **or** Puffed Rice Cereal Poached Egg—Toast Orange Marmalade—Toast	Chicken Soup Supreme Cantonese Chow Mein **or** Danish Beefsteak (FS) Buttered Rice (FS) Green Beans (FS)—Bacon Bits **or** Scalloped Corn (F) Mixed Fruit Salad—Cream Dressing **or** Lettuce Wedge—1000 Island Dressing Vanilla Cream Pudding (FS) **or** Red Plums	Fruit Juice Punch Pot Roast of Beef (FS) **or** Link Sausages—Country Gravy Potatoes—Brown Gravy (FS) Garden Spinach (FS) **or** Frozen Mixed Vegetables Green Vegetable Salad—Roquefort Dressing **or** Molded Fruit Salad Butterscotch Bars (F) **or** Pink Applesauce (S)
tuesday	Grapefruit Sections **or** Berry Nectar Oatmeal **or** Cornflakes Soft Cooked Egg **or** French Toast—Syrup	Yellow Split Pea Soup Veal Cubes—Noodles (FS)—Tomato Sauce **or** Clam Souffle Baked Potato—Butter (FS) Wax Beans (FS) **or** Stewed Tomatoes Carrot-Raisin Slaw **or** Placed Fruit Salad Ice Cream—Chocolate Sauce **or** Bartlett Pear Half (FS)	Beef-Rice Broth Chicken Fricassee—Dumplings (FS) **or** Swiss Steak—Gravy Buttered Potatoes (FS) Orange Glazed Squash (FS) **or** Brussels Sprouts Fruit Cocktail **or** Spiced Beet Salad Mincemeat Pie (F) **or** Apricot Halves in Syrup (S)
wednesday	Boysenberries in Syrup **or** Blended Juices Farina Scrambled Eggs—Bacon Clover Honey—Toast	Vegetable Soup Chipped Beef on Rice (FS) **or** Twin Salad Plate—Date Bread with Cream Cheese Oven French Fries Buttered Asparagus (FS) **or** Golden Hominy Molded Cherry Salad **or** Fresh Vegetable Salad Apple Crumble (F) **or** Freestone Peaches (S)	Pink Lemonade Baked Virginia Ham (F) **or** Roast Leg of Lamb—Gravy (S) Candied Sweet Potatoes (FS) Harvard Beets (FS) **or** Buttered Wax Beans Crisp Relishes—Crabapple **or** Harlequin Pear Salad Pineapple Upside-down Cake (F) **or** Mandarin Orange Sections (S)
thursday	Stewed Prunes **or** Tomato Juice Malt Meal Cereal **or** Ready-to-Eat Rice Cereal Poached Egg Preserves—Toast	Mulligatawny Soup Beef Pot Pie—Potato Topping (FS) **or** Pizza Pie French Bread (FS) Sliced Carrots (FS) **or** Garden Broccoli Tossed Vegetable Salad—Italian Dressing **or** Peach-Cream Cheese Salad Gelatin Cubes in Cream (FS) **or** Red Raspberries in Syrup	Beef-Noodle Soup Baked Veal Rib Chop (FS) **or** Roast Loin of Pork—Applesauce Creamed Potatoes (FS) Fresh Frozen Peas (FS) **or** Onions Au Gratin Placed Fruit Salad **or** Coleslaw Lemon Sponge Pudding (FS) **or** Green Gage Plums in Syrup
friday	Delphia Figs **or** Tangerine Juice Wheat Flake Cereal **or** High Protein Cereal Soft Cooked Egg Scotch Scone with Jam	Creamy Clam Chowder **or** Chicken Broth Tuna-Noodle Casserole (FS) **or** Scalloped Potatoes with Ham Fresh Frozen Spinach (FS) **or** Baby Green Lima Beans (F) Fruit Cocktail **or** Perfection Salad Cherry Cottage Pudding (F) **or** Sliced Bananas in Cream (S)	Mulled Cider Sole Thermidor with Almonds (FS) **or** Meat Loaf—Gravy Baked Potatoes—Butter (FS) Cut Green Beans (FS) **or** Paprika Cauliflower Melba Pear Salad **or** Green Salad—French Dressing Refrigerator Cheese Cake (F) **or** Applesauce (S)
saturday	Blackberries in Syrup **or** Fresh Frozen Orange Juice (FS) Rice Farina **or** Ready-to-Eat Malt Flake Cereal Scrambled Eggs—Bacon Bits	Minestrone Soup Italian Spaghetti (F) **or** Omelet-Cheese Sauce (S) Parsley Buttered Potato (FS) Baked Acorn Squash (FS) **or** Succotash Waldorf Salad **or** Head Lettuce Salad Apricot Crisp (F) **or** Freestone Peach Half (S)	Tomato Juice Cocktail Broiled Loin Lamb Chop (FS) **or** Corned Beef—Mustard Potatoes Au Gratin (FS) Asparagus Cuts (FS) **or** Creole Celery Minted Pear Salad **or** Fresh Vegetable Salad—French Dressing Devil's Food Cake—Fudge Frosting (F) **or** Royal Anne Cherries in Syrup (S)
sunday	Citrus Sections **or** Apricot Nectar Farina **or** Wheat Flake Cereal Poached Egg—Canadian Bacon Coffeecake	Alphabet Consomme Roast Sirloin of Beef (FS) **or** Turkey-Vegetable Pie Whipped Potatoes—Gravy (FS) Tiny Glazed Carrots (FS) **or** Pimento Lima Beans (F) Tomato Aspic Salad—Mayonnaise **or** Placed Fruit Salads Strawberry Shortcake—Whipped Cream (F) **or** Mandarin Orange Sections (S)	Cream of Asparagus Soup Chicken Loaf—Mushroom Sauce (FS) **or** Baked Ham Sandwich on Sesame Bread Buttered Potatoes (FS) Tiny Whole Beets (FS) **or** Whole Kernel Corn Fruit-Cottage Cheese Salad **or** Crisp Relishes—Pickles Lazy Daisy Cake (FS) **or** Chilled Pineapple Chunks

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread butter and a choice of beverage are to be included with each meal.

1st week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Brisket, Corned	U. S. Good	7 lbs.	20
Chipped Beef, Dried	U. S. Good	4 lbs.	
Ground Beef	U. S. Good, 5 lb. pkg.	25 lbs.	
Roast, Sirloin (B.R.T.)	U. S. Choice	27 lbs.	
Round (Bottom)	U. S. Standard	20 lbs.	60
Rump (Boneless)	U. S. Good	10 lbs.	
Steak, Swiss	U. S. Good, 4 oz. each	25 lbs.	100
Stew	U. S. Good	20 lbs.	80
LAMB			
Chops, Loin	U. S. Choice, 6 oz. each	23 lbs.	60
Leg (B.R.T.)	U. S. Choice, yearling	7 lbs.	
PORK			
Bacon, Canadian		5 lbs.	
Bacon (Sliced)	24-26-1 lb.	12 lbs.	
Ham (Pullman)	Ready-to-eat	35 lbs.	
Loin (Boneless)	Grade A, 10-12 lbs.	7 lbs.	
Sausage Links	12-1 lb.	5 lbs.	
VEAL			
Chop, Rib	U. S. Good, 5 oz. each	20 lbs.	60
Shoulder (Boneless)	U. S. Good	20 lbs.	80
FISH			
Sole	Frozen, fillets, 4 oz. each	15 lbs.	60
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	120 lbs.	
Turkeys (Eviscerated)	Grade A	30 lbs.	
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Bananas	Ripe	35 lbs.	
Grapefruit	Seedless, 70s	1 box	
Grapes	Emperor	1 box	
Lemons		1 doz.	
Oranges	176s	1 box	
FRESH VEGETABLES			
Cabbage	Bag	50 lbs.	
Carrots	Topped, bag	50 lbs.	
Celery	Pascal, 30s	1 doz. stalks	
Celery	White	1 doz. stalks	
Cucumbers		1 doz.	
Endive	Curly	1 doz. heads	
Lettuce	Head, 48s	1 crate	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	1 doz.	
Onions, White	Boilers	3 lbs.	
Parsley	Bunch	1 doz.	
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag No. 1	400 lbs.	
Radishes	Bunch	1 doz.	
Squash, Acorn		45 lbs.	
Tomatoes	Repacked (5 x 6)	1 lug (30 lbs.)	
FROZEN FRUITS			
Apples	Sliced, 8 lb. can, 5-1 sugar	24 lbs.	
Apricots	Halves, 8 lb. can, 5-1 sugar	24 lbs.	
Boysenberries	8 lb. can, 5-1 sugar	8 lbs.	
Cherries	5-1 sugar, pitted, 8 lb. can	16 lbs.	
Grapefruit Sections	8 lb. can, 5-1 sugar	8 lbs.	
Orange Juice	Con., 32 oz. can	6 cans	
Orange and Grapefruit Sections	8 lb. can, 5-1 sugar	8 lbs.	
Pineapple	Chunks, 8 lb. can, 5-1 sugar	8 lbs.	
Raspberries, Red	8 lb. can, 5-1 sugar	8 lbs.	
Strawberries	Sliced, 8 lb. can, 5-1 sugar	24 lbs.	
FROZEN VEGETABLES			
Asparagus	Cuts, 2½ lb. pkg.	10 lbs.	60
Asparagus	Spears, 2½ lb. pkg.	15 lbs.	90
Beans, Green	Cuts, 2½ lb. pkg.	10 lbs.	60
Beans, Green	Julienne, 2½ lb. pkg.	15 lbs.	90
Beans, Lima	Small, green, 2½ lb. pkg.	5 lbs.	30
Beans, Wax	Cuts, 2½ lb. pkg.	17½ lbs.	105
Broccoli	Stems and buds 2½ lb. pkg.	2½ lbs.	15
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	10 lbs.	60
Spinach	Chopped, 2½ lb. pkg.	25 lbs.	150
Squash, Winter	3 lb. pkg.,	3 lbs.	15
Succotash	2½ lb. pkg.	2½ lbs.	15
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

PLEASE CUT ALONG THIS LINE

THIS PAGE HAS BEEN PERFORATED FOR EASY REMOVAL

2nd WEEK NORTH-NORTHWEST SELECTIVE FALL CYCLE MENU

(MENUS TO BE USED DURING SEPTEMBER, OCTOBER AND NOVEMBER)

—prepared by Jean Ishida, chief dietitian, Maynard Hospital, Seattle, Wash.

	breakfast	noon	night
monday	Fresh Applesauce **or** Grapefruit Juice Malt Meal Cereal **or** Puffed Rice Cereal Soft Cooked Egg Cinnamon Toast	Turkey-Noodle Soup Creamed Fresh Salmon and Peas on Toast (FS) **or** Beef Pie—Cheese Topping Baked Potato—Butter (FS) Buttered Wax Beans (FS) **or** Fresh Frozen Broccoli Fruit Cocktail **or** Tossed Vegetable Salad Caramel Pudding (FS) **or** Red Plums	Scotch Broth Roast Leg of Veal (FS)—Dressing—Gravy (F) **or** Fried Chicken Oven Browned Potato (FS) Garden Peas (FS) **or** Whole Kernel Corn Sunshine Salad **or** Marinated Vegetable Salad Blueberry Cobbler (F) **or** Bartlett Pear Halves in Syrup (S)
tuesday	Green Gage Plums in Syrup **or** Tangerine Juice Farina **or** Bran Cereal Scrambled Eggs— Sausage Links Sugar Doughnut	Vegetable Soup Hot Roast Beef Sandwich (F) **or** Cheese Strata—Toast—Jelly (S) Whipped Potatoes (FS) Garden Spinach—Lemon (FS) **or** Scalloped Tomatoes Mixed Fruit Salad—Cream Dressing **or** Celery Fans and Carrot Curls Fruited Cherry Gelatin—Cream (FS) **or** Apricot Halves in Syrup	Pink Lemonade Lamb Pattie—Bacon Curl (FS) **or** Roast Loin of Pork—Gravy Potatoes Au Gratin (FS) Green Beans (FS)—Almonds (F) **or** Paprika Cauliflower Sliced Tomato Salad—Mayonnaise **or** Pear-Cream Cheese Salad Chocolate Cream Pudding (F) **or** Freestone Peach Half (S)
wednesday	Citrus Sections **or** Peach Nectar Oatmeal **or** High Protein Cereal Poached Egg Homemade Coffeecake	Potato Chowder Hungarian Goulash on Buttered Noodles (F) **or** Tuna-Rice Au Gratin (S) Parsley Buttered Carrots (FS) **or** Tiny Whole Onions and Peas Pineapple-Cottage Cheese Salad **or** Green Salad—Caesar Dressing Grapenuts Custard (FS) **or** Chilled Boysenberries in Syrup	Beef-Noodle Soup Ham Loaf—Orange Glaze (F) **or** Sliced Chicken (S) Mashed Potatoes—Butter (FS) Tiny Whole Beets (FS) **or** Pimento Lima Beans (F) Molded Cranberry Salad **or** Crisp Relishes—Crabapple Spice Cake—Lemon Frosting (F) **or** Applesauce (S)
thursday	Stewed Prunes **or** Blended Juice Farina **or** Wheat Flake Cereal Soft Cooked Egg **or** Buttermilk Hotcakes—Syrup	Split Pea Soup Lamb Kabob—Almond Rice (F) **or** Large Canned Fruit-Cottage Cheese Salad (S) Scalloped Potatoes (FS) Baked Glazed Acorn Squash (FS) **or** Lemon-Buttered Brussels Sprouts Pear-Grated Cheese Salad **or** Fresh Romaine Salad—Dressing Apricot Crisp (F) Mandarin Orange Sections (S)	Vegetable Juice Cocktail Roast Round of Beef (FS) **or** Chicken Giblets on Rice Potatoes—Brown Gravy (FS) Asparagus Cuts (FS) **or** Scalloped Corn Tossed Vegetable Salad—Dressing **or** Stuffed Prune Salad Tapioca Cream Pudding (FS)—Strawberries **or** Sliced Bananas—Cream
friday	Blackberries in Syrup **or** Pineapple Juice Rice Farina **or** Bran Flake Cereal Scrambled Eggs—Bacon Toast—Honey	Oyster Stew Macaroni and Cheese (FS) **or** Turkey Salad in Tomato Oven French Fries Buttered Peas (FS) **or** Creamed Spinach Fruit Cocktail **or** Shredded Lettuce—French Dressing Lemon Snow—Custard Sauce (FS) **or** Delphia Figs	Iced Punch Golden Baked Halibut (FS)—Tartar Sauce **or** Meat Loaf—Chili Sauce Paprika Potatoes (FS) Green Beans—Parmesan (FS) **or** Buttered Mixed Vegetables Apple-Date Salad **or** Cole Slaw Red Cherry Crumble (F) **or** Bartlett Pear Halves in Syrup (S)
saturday	Grapefruit Sections **or** Grape Juice Malt Meal Cereal **or** Ready-to-Eat Bran Flake Cereal Poached Egg Toast—Jelly	Creole Chicken Noodle Soup Beef Pot Pie (FS) **or** Frankfurter on a Bun—Mustard Whipped Potatoes—Butter (FS) Mashed Squash—Nutmeg (FS) **or** Pimento Wax Beans Peach-Gingerale Salad **or** Tossed Green Salad—Dressing Lime Sherbet (FS) **or** Fresh Fruit Compote	Bouillon Baked Ham (F) **or** Lamb Steak—Mushroom Sauce (S) Candied Yams (FS) Sliced Beets (FS) **or** Cauliflower Au Gratin Spiced Apricot Salad **or** Crisp Relishes Lemon Custard Cake (FS) **or** Chilled Pineapple Slice in Syrup
sunday	Stewed Apricots **or** Fresh Frozen Orange Juice Farina **or** Ready-to-Eat Rice Cereal Toast—Crisp Bacon	Beef-Alphabet Broth Baked Chicken (FS) **or** Broiled Hamburger Steak Oven Browned Potato (FS) Buttered Carrot Slices (FS) **or** Garden Broccoli Crisp Relishes—Olives **or** Placed Fruit Salad Cranberry Crunch (F) **or** Dark Sweet Cherries in Syrup (S)	Vegetable Soup Braised Veal—Fresh Peas on Rice (FS) **or** Egg Salad Sandwich on White or Dark Bread Potato Chips Stewed Tomatoes (F) **or** Asparagus Spears (S) Molded Fruit Salad **or** Green Salad—Dressing Fruited Gelatin—Cream (FS) **or** Freestone Peach Half

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverage are to be included with each meal.

2nd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Frankfurters	All beef, 8-1 lb.	5 lbs.	
Ground Beef	U. S. Good, 5 lb. pkg.	35 lbs.	
Roast, Sirloin (B.R.T.)	U. S. Choice	35 lbs.	
Round (Top, Boneless)	U. S. Good	20 lbs.	60
Stew	U. S. Good	30 lbs.	
LAMB			
Ground, Shoulder	U. S. Good	15 lbs.	60
Shoulder (Boneless)	U. S. Good	35 lbs.	100
Steaks, Shoulder	U. S. Good, 5 oz. each	7 lbs.	
PORK			
Bacon (Sliced)	24-26-1 lb.	6 lbs.	
Ham (Pullman)	Ready-to-eat	35 lbs.	
Loin (Boneless)	Grade A, 10-12 lbs.	7 lbs.	
Sausage Links	12-1 lb.	6 lbs.	
VEAL			
Leg (B.R.T.)	U. S. Good	20 lbs.	
Shoulder (Boneless)	U. S. Good	20 lbs.	60
FISH			
Halibut	Steaks, 5 oz. each	19 lbs.	
Salmon	Red	20 lbs.	
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	20 lbs.	

Item, Specifications, Amounts & No. of Servings		
Turkeys (Eviscerated)	Grade A	10 lbs.
Fryers (Eviscerated)	Grade A, 2½ lb. av.	62 lbs.
Livers, Chicken	1 lb. pkg.	4 lbs.
FRESH FRUITS		
Apples	Jonathan, 113s	1 box
Bananas	Ripe	25 lbs.
Grapefruit	Seedless, 70s	1 box
Grapes	Emperor	1 box
Lemons		1 doz.
Oranges	176s	1 box
FRESH VEGETABLES		
Cabbage	Bag	50 lbs.
Carrots	Topped, bag	50 lbs.
Celery	Pascal, 30s	1 doz.
Celery	White	2 doz.
Cucumbers		1 doz.
Endive	Curly	1 doz. heads
Lettuce	Head, 48s	1 crate
Onions, Dry	Yellow, bag	50 lbs.
Onions, Green	Bunch	1 doz.
Onions, White	Boilers	3 lbs.
Parsley	Bunch	1 doz.
Potatoes, Sweet	Hamper	50 lbs.
Potatoes, White	Bag No. 1	400 lbs.
Radishes	Bunch	1 doz.
Romaine		1 doz. heads
Squash, Acorn		45 lbs.
Tomatoes	Repacked (5 x 6)	1 lug (30 lbs.)

Item, Specifications, Amounts & No. of Servings			
Watercress	Bunch	1 doz.	
FROZEN FRUITS			
Apricots	Halves, 8 lb. can, 5-1 sugar	8 lbs.	
Blueberries	Dry, 8 lb. can	16 lbs.	
Boysenberries	8 lb. can, 5-1 sugar	8 lbs.	
Cherries	5-1 sugar, pitted, 8 lb. can	16 lbs.	
Grapefruit Sections	8 lb. can, 5-1 sugar	8 lbs.	
Orange Juice	Con., 32 oz. can	6 cans	
Strawberries	Sliced, 8 lb. can, 5-1 sugar	8 lbs.	
FROZEN VEGETABLES			
Asparagus	Cuts, 2½ lb. pkg.	10 lbs.	60
Asparagus	Spears, 2½ lb. pkg.	2½ lbs.	15
Beans, Green	Cuts, 2½ lb. pkg.	10 lbs.	60
Beans, Green	Julienne, 2½ lb. pkg.	10 lbs.	60
Beans, Lima	Small, green, 2½ lb. pkg.	2½ lbs.	15
Beans, Wax	Cuts, 2½ lb. pkg.	17½ lbs.	105
Broccoli	Stems and buds 2½ lb. pkg.	17½ lbs.	105
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	5 lbs.	30
Peas	2½ lb. pkg.	42½ lbs.	255
Spinach	Chopped, 2½ lb. pkg.	17½ lbs.	105
Squash, Winter	3 lb. pkg.	15 lbs.	90
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

PLEASE CUT ALONG THIS LINE

THIS PAGE HAS BEEN PERFORATED FOR EASY REMOVAL

3rd WEEK NORTH-NORTHWEST SELECTIVE FALL CYCLE MENU

(MENUS TO BE USED DURING SEPTEMBER, OCTOBER AND NOVEMBER)

—prepared by Jean Ishida, chief dietitian, Maynard Hospital, Seattle, Wash.

	breakfast	noon	night
monday	Red Raspberries in Syrup (F) **or** Pineapple Juice (S) Wheat Cereal **or** Ready-to-Eat Rice Cereal Scrambled Eggs Toast—Preserves	Cream of Chicken Soup Seafood Stuffed Baked Potato (FS) **or** Meatballs—Gravy Parsley Buttered Potato Asparagus Spears (FS) **or** Cream Style Corn (F) Carrot-Raisin Slaw **or** Fresh Citrus Salad Homemade Cookies (FS) **or** Apricot Halves in Syrup	Vegetable Juice Cocktail Pot Roast of Beef (FS) **or** Link Sausages—Country Gravy Mashed Potatoes—Gravy (FS) Baked Glazed Acorn Squash (FS) **or** Brussels Sprouts Fresh Vegetable Salad—Dressing **or** Placed Fruit Salad French Apple Pie (F) **or** Bartlett Pear Halves in Syrup (S)
tuesday	Red Plums in Syrup **or** Tangerine Juice (S) Oatmeal **or** Wheat Flake Cereal Poached Egg Wheat Muffin	Split Pea Soup Braised Diced Lamb on Noodles (FS) **or** Fruit Salad Plate—Date Bread Corn Bread (FS) Buttered Spinach (FS)—Bacon Bits **or** Mixed Vegetables Pear-Grated Cheese Salad **or** Crisp Relishes Bread Pudding (FS) **or** Fresh Grapes	Bouillon Braised Sirloin Tips—Mushrooms (FS) **or** Baked Spareribs—Apple Dressing Baked Potato—Butter (FS) Fresh Frozen Peas (FS) **or** Buttered Baby Lima Beans Green Salad—Roquefort Dressing **or** Melba Peach Salad Orange Torte—Whipped Cream (F) **or** Royal Anne Cherries in Syrup (S)
wednesday	Stewed Prunes **or** Blended Juice Farina **or** Bran Cereal Soft Cooked Egg **or** French Toast—Syrup	Vegetable Soup Scalloped Potatoes—Chipped Beef (FS) **or** Beef Croquettes—Parsley Sauce Stewed Tomatoes—Basil (F) **or** Green Beans (S) Fruit Cocktail **or** Perfection Salad Lemon Meringue Pudding (FS) **or** Green Gage Plums in Syrup	Mulled Cider Roast Leg of Veal—Gravy (FS) **or** Beef Liver—Crisp Bacon Oven-browned Potato (FS) Parsley Buttered Carrots (FS) **or** Garden Broccoli Romaine Salad—Celery Seed Dressing **or** Spiced Apricot Salad Mincemeat Turnover (F) **or** Applesauce (S)
thursday	Citrus Sections **or** Peach Nectar (S) Rice Farina **or** High Protein Cereal Scrambled Eggs—Bacon Toast—Honey Butter	Cream of Tomato Soup Grilled Hamburger on Bun—Relish (F) **or** Cheese Strata—Toast—Jelly (S) Whipped Potatoes—Butter Tiny Whole Beets (FS) **or** Creole Celery Potato Salad **or** Placed Fruit Salad Ice Cream—Rum Butter Topping **or** Mandarin Orange Sections (S)	Beef-Rice Broth Baked Young Chicken (FS) **or** Corn Sausage Mushroom Casserole Potatoes Au Gratin (FS) Wax Beans—Bacon Bits (FS) **or** Golden Hominy Pineapple-Cranberry Salad **or** Tossed Green Salad—Dressing Banana Cream Cake (FS) **or** Blackberries in Juice
friday	Delphia Figs **or** Pineapple-Grapefruit Juice Wheat Flake Cereal **or** Cornflakes Poached Egg English Muffin	Boston Clam Chowder Omelet—Toast—Jelly (FS) **or** Lamb Curry on Parslied Rice Paprika Buttered Potatoes (FS) Fresh Frozen Spinach (FS) **or** Pimento Wax Beans Waldorf Salad—Cream Dressing **or** Crisp Relishes—Spiced Crabapple Apricot Crumble (F) **or** Freestone Peaches (S)	Fruit Juice Punch Golden Baked Red Snapper—Tartar Sauce (FS) **or** Swiss Steak—Gravy Parsley Buttered Potatoes (FS) Mixed Vegetables (F) **or** Tiny Whole Carrots (S) Sliced Tomato Salad—Mayonnaise **or** Fruit Cocktail Chocolate Cream Pudding (F) **or** Bartlett Pear Halves in Syrup (S)
saturday	Boysenberries in Syrup **or** Fresh Frozen Orange Juice (S) Cornmeal Mush **or** Ready-to-Eat Cereal Crisp Bacon Raisin Toast	Minestrone Soup Beef Stew—Potato Topping (FS) **or** Chef's Salad Bowl—1000 Island Dressing Cornbread Buttered Asparagus (FS) **or** Scalloped Tomatoes Molded Fruit Salad **or** Peach-Cream Cheese Salad (S) Red Cherry Cobbler (F) **or** Peeled Apricot Halves in Syrup (S)	Beef-Rice Broth Breaded Veal Chop (FS) **or** Baked Beef Hash—Gravy Creamed Potatoes (FS) Garden Peas (FS) **or** Mexicorn (F) Grapefruit and Orange Section Salad **or** Spiced Beet Salad Apple Dumpling—Cream (F) **or** Banana Slices in Cream (S)
sunday	Grapefruit Sections **or** Apricot Nectar (S) Farina **or** Bran Flake Cereal Soft Cooked Egg—Canadian Bacon Coffeecake	Pineapple Juice Cocktail Baked Virginia Ham (F) **or** Roast Leg of Lamb—Gravy (S) Candied Yams (FS) Green Beans (FS)—Almonds (F) **or** Baked Onions Au Gratin Minted Pear Salad **or** Fresh Vegetable Salad—French Dressing Black Raspberry Gelatin—Cream (FS) **or** Green Gage Plums in Syrup	Cream of Mushroom Soup Chicken a la King on Rice (FS) **or** Grilled Cheese Sandwich Oven French Fries Sliced Beets (FS) **or** Buttered Cabbage Fruit Salad **or** Celery Fans—Olives Angel Food Cake (FS) **or** Pink Applesauce

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverage are to be included with each meal.

3rd week market order for perishables (per 50 beds)

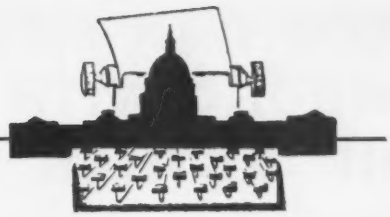
Item, Specifications, Amounts & No. of Servings			
BEEF			
Chipped Beef, Dried	U. S. Good	5 lbs.	
Ground Beef	U. S. Good, 5 lb. pkg.	45 lbs.	
Liver	Steer, sliced	5 lbs.	20
Round (Bottom)	U. S. Standard	25 lbs.	
Sirloin Tip	U. S. Choice	20 lbs.	60
Steak, Swiss	U. S. Good, 4 oz. each	5 lbs.	20
Stew	U. S. Good	20 lbs.	80
LAMB			
Leg (B.R.T.)	U. S. Choice, yearling	7 lbs.	
Shoulder (boneless)	U. S. Good	30 lbs.	
PORK			
Bacon, Canadian		5 lbs.	
Bacon (Sliced)	24-26-1 lb.	6 lbs.	
Ham (Pullman)	Ready-to-eat	35 lbs.	
Sausage Links	12-1 lb.	10 lbs.	
Spareribs	Grade A, 3-1 lb.	10 lbs.	20
VEAL			
Chop, Rib	U. S. Good, 5 oz. each	20 lbs.	60
Leg (B.R.T.)	U. S. Good	20 lbs.	60
FISH			
Red Snapper	Fillets, 4 oz. each	15 lbs.	60
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	57 lbs.	
Fryers (Eviscerated)	Grade A, 2½ lb. av.	38 lbs.	

Item, Specifications, Amounts & No. of Servings		
FRESH FRUITS		
Apples	Jonathan, 113s	1 box
Bananas	Ripe	25 lbs.
Grapefruit	Seedless, 70s	1 box
Grapes	Emperor	1 box
Lemons		1 doz.
Oranges	176s	1 box
FRESH VEGETABLES		
Cabbage	Bag	50 lbs.
Carrots	Topped, bag	50 lbs.
Celery	Pascal, 30s	1 doz. stalks
Celery	White	1 doz. stalks
Cucumbers		1 doz.
Endive	Curly	1 doz. heads
Lettuce	Head, 48s	1 crate
Onions, Dry	Yellow, bag	50 lbs.
Onions, Green	Bunch	1 doz.
Onions, White	Boilers	3 lbs.
Parsley	Bunch	1 doz.
Potatoes, Sweet	Hamper	50 lbs.
Potatoes, White	Bag No. 1	400 lbs.
Radishes	Bunch	1 doz. bunches
Romaine	Bunches	1 doz.
Squash, Acorn		30 lbs.
Tomatoes	Repacked (5 x 6)	1 lug (30 lbs.)
FROZEN FRUITS		
Apples	Sliced, 8 lb. can, 5-1 sugar	32 lbs.
Apricots	Halves, 8 lb. can, 5-1 sugar	32 lbs.

Item, Specifications, Amounts & No. of Servings			
Blackberries	8 lb. can, 5-1 sugar	8 lbs.	
Cherries	5-1 sugar, pitted, 8 lb. can	24 lbs.	
Orange Juice	Con., 32 oz. can	6 cans	
Orange and Grapefruit Sections	8 lb. can, 5-1 sugar	24 lbs.	
Raspberries, Red	8 lb. can, 5-1 sugar	8 lbs.	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	30 lbs.	180
Beans, Green	Cuts, 2½ lb. pkg.	2½ lbs.	15
Beans, Green	Julienne, 2½ lb. pkg.	15 lbs.	90
Beans, Lima	Small, green, 2½ lb. pkg.	2½ lbs.	15
Beans, Wax	Cuts, 2½ lb. pkg.	12½ lbs.	75
Broccoli	Stems and buds 2½ lb. pkg.	2½ lbs.	15
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	20 lbs.	120
Spinach	Chopped, 2½ lb. pkg.	30 lbs.	180
Vegetables, Mixed	2½ lb. pkg.	5 lbs.	30

PLEASE CUT ALONG THIS LINE

THIS PAGE HAS BEEN PERFORATED FOR EASY REMOVAL



Care of Aged Holds Spotlight

Congressional attention continued on providing health care of aged, despite the concluding of Forand bill hearings in late July.

The Senate Subcommittee on the Aged and Aging scheduled a series of month-long hearings on problems of the elderly.

Opening the hearings, Chairman McNamara (D-Mich.) said:

"The time has long passed for the country to be able to ignore this great domestic challenge of the mid-century. In the decades to come, we should never allow it to be said that Americans—young and old alike—were foolhardy enough to waste the productive contributions of an expanding population of men and women reaching the age of 70 and beyond."

Seven major subjects were covered during the hearings:

- Housing needs of the elderly and the responsibility of the federal government in this area.
- Job discrimination against the worker over 45.
- Financing of adequate medical care for the aged and aging.
- Conditions of nursing homes and the problem of setting treatment standards.
- Measures to prevent physical and mental health deterioration.
- Need of adequate income for those who have retired.
- Ensuring a productive, meaningful life for those who retire from regular employment.

Later this year, other hearings will take place in selected major cities. A final committee report and recommendation will be made to the full Senate before the second session of the 86th Congress.

Another report due on the health care of the aging is Department of Health, Education, and Welfare staff study on a voluntary system of employee contribution to a government-run insurance pool.

At House Hearings AHA Supports Federal Employee Health Plan

The American Hospital Association gave strong support to a Senate-passed bill (S. 2162) establishing

YOU SAVE money for your hospital when you buy Gudebrod silk and cotton sutures.

Sterilize Gudebrod sutures as you need them and save **UP TO 50%** of your suture **COST.** Every improvement **IN** non-absorbable sutures is incorporated in these **SUTURES . . .** manufactured by Gudebrod for eighty-nine years.

Reduce costs **WITH** no sacrifice in quality. Buy **GUDEBROD** and save. Write for the Gudebrod story, "How You Can Save up to 50% of Your Suture Cost."

Gudebrod BROS.
SILK CO., INC.

Surgical Division:
225 West 34th St.,
New York 1, N.Y.

Executive Offices:
12 South 12th St.,
Philadelphia 7, Pa.

CHICAGO BOSTON LOS ANGELES

Shroudpac

THE COMPLETE PACKAGE FOR HANDLING THE DECEASED

IN THE CONVENIENT DISPENSER OF SIX

NO MORE SEARCHING • NO MORE IMPROVISING

Featured by these Leading . . .

HOSPITAL SUPPLY DISTRIBUTORS

throughout the United States and Canada

A. S. Aloe Co. — American Hospital Supply Corp.
E. F. Mahady Co. — Meinecke & Co., Inc.
Physicians and Hospitals Supply Co., Inc.
Will Ross, Inc. — Ingram & Bell Ltd. (Canada)

READY FOR IMMEDIATE USE

Shroudpac is the time saving procedure for easier, cleaner and faster handling of the deceased.

Each SHROUDPAC KIT contains —

- Opaque-Hospital White-Linen Weave-Plastic Shroud Sheet
- Chin Strap • Identification Tags
- Cellulose Pads • Tie Tapes
- Polythelene bag for personal belongings.

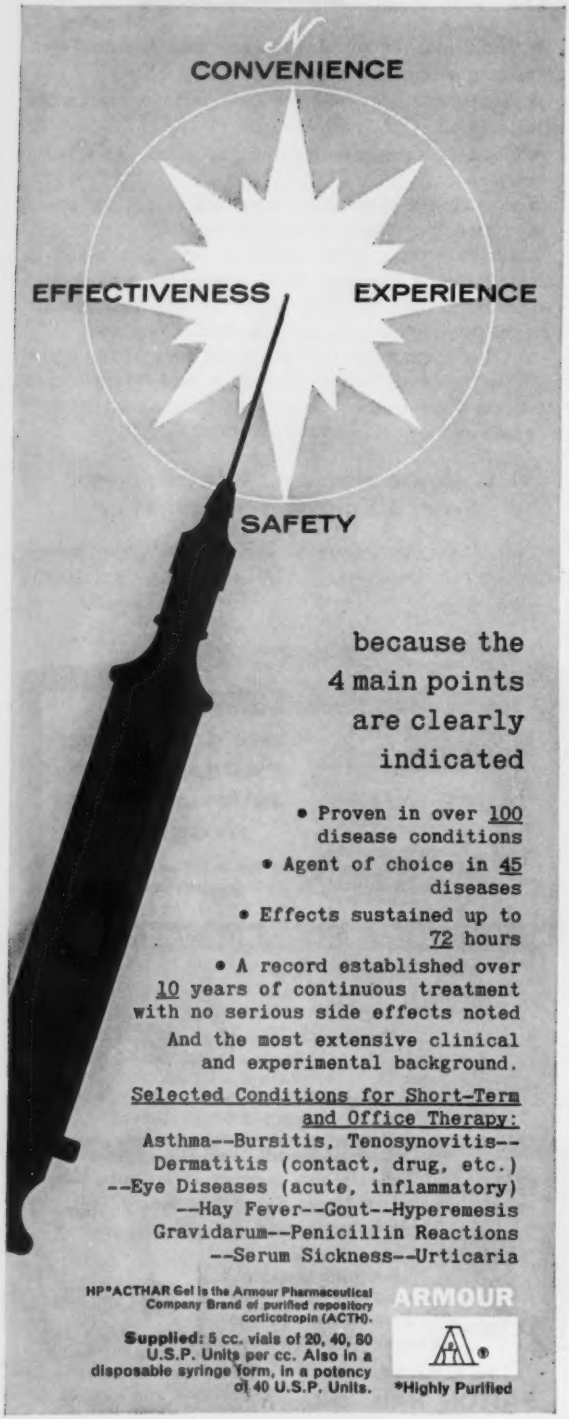
For Further Information . . . Contact Your Distributor

PATTON HALL, INC.

SHROUDPAC is an exclusive product of Patton Hall, Inc.

2265 W. ST. PAUL AVE. • CHICAGO 47, ILLINOIS

YOU CAN'T GO WRONG WITH HP* ACTHAR® GEL


CONVENIENCE
EFFECTIVENESS
EXPERIENCE
SAFETY
because the 4 main points are clearly indicated
• Proven in over 100 disease conditions
• Agent of choice in 45 diseases
• Effects sustained up to 72 hours
• A record established over 10 years of continuous treatment with no serious side effects noted
And the most extensive clinical and experimental background.
Selected Conditions for Short-Term and Office Therapy:
Asthma--Bursitis, Tenosynovitis--Dermatitis (contact, drug, etc.) --Eye Diseases (acute, inflammatory) --Hay Fever--Gout--Hyperemesis Gravidarum--Penicillin Reactions --Serum Sickness--Urticaria
HP*ACTHAR Gel is the Armour Pharmaceutical Company Brand of purified repository corticotropin (ACTH).
Supplied: 5 cc. vials of 20, 40, 80 U.S.P. Units per cc. Also in a disposable syringe form, in a potency of 40 U.S.P. Units.
ARMOUR
*Highly Purified

ARMOUR PHARMACEUTICAL COMPANY • KANKAKEE, ILLINOIS

Armour Means Protection

health insurance for more than two million federal employees. In a letter to Tom Murray (D-Tenn.), chairman of the House Post Office and Civil Service Committee, the Association based its support of S. 2162 on eight major points:

1. The bill recognizes the fact that voluntary prepaid insurance is the most economical means by which employees and their families can budget for their health needs, in keeping with basic concepts of the freedom of choice of both physician and hospital.
2. The benefits to be provided are reasonably comprehensive in scope.
3. All employees have the opportunity to select a service benefit plan for their basic hospital benefits.
4. The bill represents government recognition of the commonly accepted need for both payroll deductions and employer contributions.
5. The bill provides a government contribution sufficient to enable the employees to obtain reasonably comprehensive protection for themselves and their families.
6. Care has been taken to relate supplementary benefits to the basic service benefit program, so as to meet the needs of the recipients in an advantageous manner.
7. The bill takes cognizance of the particular problems retired employees have in maintaining health insurance.
8. Recognition is given to the benefits to be derived from an advisory council in the continued administration of the program.

Testifying for the Blue Cross Association, J. Douglas Colman, its vice president and secretary, told the House Post Office and Civil Service Committee that the association hoped for early passage of H.R. 8210, identical to the Senate-passed bill S. 2162.

Mr. Colman maintained that there is a "realistic relationship" between the bill's benefits and its costs.

Despite strong support for the Senate-passed bill from all interested groups, Chairman Murray has declared that "there is a strong reason for waiting" to see what next year's budget situation is before the House acts. Sponsors of the legislation say that to begin on schedule it must pass Congress this summer.

Mr. Murray also declared that, if the bill were not geared to the Eisenhower administration's policy which holds that federal government should pay no more than one-third of the cost, the bill would probably be vetoed.

The program would initially cost an estimated $300 million a year with the federal government and its employees sharing costs on a 50-50 basis. The bill fixes maximum benefits and payments. Employees would choose among Blue Cross and insurance plans for coverage.

The Government Employees Council of AFL-CIO testified before the committee that although it favored a government contribution of two-thirds of the cost, it would support the 50-50 sharing provided in the bill.

International Health Programs Viewed At House Hearings

House hearings were in progress early this month

on a resolution authorizing $50 million annually for international health research.

The Senate passed the measure in May by a vote of 63 to 17.

The resolution would create at the National Institutes of Health a ninth institute called the National Institute for International Medical Research. The $50 million authorization would be used for grants to public and private institutions, agencies, and individuals abroad.

The funds would also help furnish technical assistance here and abroad for the international exchange of health experts; the improvement or alteration of research facilities in hospitals and laboratories; and for the support of international health conferences.

Supporting the bill, the American Hospital Association told Congress that the program would profoundly affect the progress of health research and training throughout the world.

Plan for Surplus Property Distribution

HEW Secretary Flemming has announced a new plan for making federal surplus property available to hospitals and other nonprofit institutions. He said the General Services Administration, the Department of Defense, and the Department of Health, Education, and Welfare—the three agencies principally concerned with the disposal of government surplus property—are working cooperatively on a plan which will:

- Speed up the process of surplus property disposal.
- Increase the use of surplus property by the federal government and others eligible to obtain it.

Two kinds of property regularly become available. In one category falls the property which, while no longer needed by the agency that bought it, still may be valuable to other federal agencies or to groups declared eligible under the law by the Department of Defense. This property must be reported by General Services Administration to federal agencies so they may determine whether they have any use for it. This "reportable" property is generally in good condition.

Property of poor condition and impracticable for listing falls in the second category. Much of this property, known as "nonreportable" does, however, have a great deal of value for hospitals and civil defense purposes.

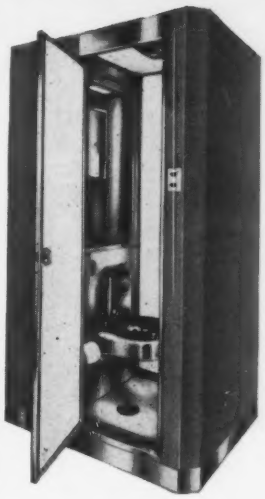
The plan with respect to reportable property is as follows:

Once property has been declared excess to its needs by the agency which bought it, GSA will have 60 days—as against the present 90—in which to determine whether other federal agencies or groups declared eligible by the Department of Defense want to claim it.

Any property not claimed during this period will be set aside for exclusive screening by the Department of Health, Education, and Welfare to determine which items would be of use to hospitals and other institutions.

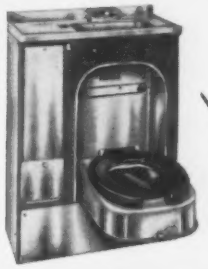
When the new plan goes into effect, HEW will know definitely that any property it claims will actually be available for hospital use.

SPACE-SAVER



MODEL MAS-236V: Lavatory Shower Cabinet. Includes shower, fold-away toilet, wash-basin, medicine cabinet, mirror, light fixture, exhaust fan, soap dish, etc. Size 32½" x 45½". Height 81". A complete bathroom for less than $1,000.

MODEL FB-220: Includes fold-away toilet, stationary wash-basin, toilet tissue dispenser. Size: 12½" x 27⅝". Height 34⅝". Complete Lavatory for less than $450.



Revolutionary New

SPACE-SAVER LAVATORIES

READY TO INSTALL IN ANY HOSPITAL ROOM

Hospital administrators and architects have given a glowing welcome to this unique advancement. Here at last, is a lavatory unit that is complete, compact and so marvelously efficient it requires only one-fourth the space of a conventional lavatory fixture.

Just the thing for new buildings where costly space must be conserved—or for bringing old hospital rooms up to date quickly and economically. SPACE-SAVERS are made of sanitary stainless steel, highly polished, easy to keep clean. Supply complete bathroom facilities, function without maintenance. Shipped ready for final hook up to drain and water lines. Will last for life.

Write for Color Brochure and Price List.

ANGELO COLONNA, INC.

TRAVEL-LAV DIVISION Dept. H-89

Westmoreland & Boudinot Sts.

Philadelphia 34, Pa.

ministration from Columbia University.

● **Manley C. Solheim** has been appointed administrator of Jeanes Hospital, Philadelphia. He succeeds the late F. William Burg Jr. Mr. Solheim was formerly administrator of Tioga County General Hospital, Waverly, N. Y.

● **R. T. Stevenson, M.D.** (see Miller item)

● **Osmund H. Webster** has been appointed assistant administrator of Children's Medical Center, Dallas. He has been an administrative resident at East Tennessee Baptist Hospital, Knoxville, and is a graduate of the Washington University program in hospital administration.

● **William E. Worcester Jr.,** has been appointed hospital administration advisor with the International Cooperation Administration's mission to the Philippines. In Manila, he will serve as ICA hospital administrator advisor to the Philippine government and will also work with the Institute of Hygiene at the University of the Philippines. He was formerly administrator of the Valley Hospital, Ridgewood, N.J. Mr. Worcester is a graduate of the Columbia University program in hospital administration.

Special Notes

ANNIVERSARY: Group Hospitalization, Inc., of Washington, D.C., (Blue Cross), celebrated its 25th anniversary.

ANNIVERSARY: Hurley Hospital, Flint, Mich., celebrated the 50th anniversary of its School of Nursing.

ELECTED: I. Herbert Scheffer, M.D., executive director, Miriam Hospital, Providence, R.I., and past president of the Hospital Association of Rhode Island, as president of the Military Government Public Health Society.

HONORED: Alexandria (Va.) Hospital received the top public relations achievement award for the State of Virginia for first place among the state's noncommercial organizations, "in recognition of outstanding achievement during the past year in the field of public relations in Virginia, contributing to public understanding and confidence in the institution and its services." The award was presented to Mrs. Bettie McNamara Fretz, public relations director of the hospital, at the 11th Annual Virginia Public Relations Conference, Old Point Comfort.

HONORED: David T. Beals was given a plaque by the Missouri Hospital Association for his outstanding service to the health and hospital field. Mr. Beals is executive vice president of the board of St. Luke's Hospital, Kansas City, Mo., is a board member, treasurer, member of the executive committee, chairman of the finance committee, and member of the planning committee of the Kansas City Area Hospital Association. He is also vice president of the local Blue Cross board.

HONORED: C. G. Darling Jr., M.D., chief of surgery since 1927, at St. Joseph Mercy Hospital, Pontiac, Mich., was honored at a dinner at the hospital. The testimonial banquet was given by the Sisters of Mercy in recognition of Dr. Darling's 32 years of service to the hospital. Dr. Darling was presented a bronze plaque citing his long service and noting that his father, also a surgeon, helped found the Sister's order in Ann Arbor.

HONORED: Robert A. Kimbrough Jr., M.D., director of the Division of Obstetrics and Gynecology at Pennsylvania Hospital, Philadelphia, was presented a plaque at a testimonial dinner in his honor, which read: "An affectionate tribute to Robert Alexander Kimbrough Jr., M.D., by his residents in appreciation of his tireless effort and unfailing loyalty as their teacher, counselor, and friend."

HONORED: A. C. McGugan, M.D., superintendent of the University of Alberta Hospital, Edmonton, was named recipient of the George Findlay Stephens Memorial Award for 1959. The award is bestowed in recognition of noteworthy service in the hospital field in Canada and is in memory of Dr. George Findlay Stephens, who was a charter member of the American College of Hospital Administrators and the first Canadian to serve as president of the American Hospital Association. Dr. McGugan is a Fellow in the College and has devoted a lifetime to serving hospitals and community health.

DR. McGUGAN

HONORED: Kenneth S. McLaren has been named the recipient of the University of Toronto's $1000 Robert Wood Johnson award in the department of hospital administration. The annual award is made to the member of the class who, at the end of the residency year, shows the most promise of making a real contribution toward the advancement of hospitals and hospital administration. Mr. McLaren is presently assistant professor in the university's department of hospital administration.

Deaths

Raymond W. Brooke, administrator, Wyckoff Heights Hospital, Brooklyn, died suddenly on June 12 at the age of 58. Mr. Brooke came to Wyckoff Heights in 1954 from Roosevelt Hospital, New York City, where he was for two years associate director. Before he came to New York, Mr. Brooke was with Johns Hopkins Hospital, Baltimore, and Easton (Md.) Memorial Hospital. Mr. Brooke is survived by his wife, Lovice, and his mother, Mrs. Cora Lee Brooke.

George A. W. Currie, M.D., died on July 15 at the age of 45. He had been superintendent of Hospital for Sick Children, Toronto. Prior to that he had been administrator of University of Texas Medical Branch Hospitals, Galveston, and earlier, of Colorado General Hospital, Denver. While in Denver, Dr. Currie was also assistant professor of public health and preventive medicine at the University of Colorado Medical School. He was a member of the American Hospital Association, American College of Hospital Administrator, and American Public Health Association.

A. E. Hoppe, 55, died June 14 after a long illness. For 20 years he had been owner and director of Culver City (Calif.) Hospital, but retired in 1958. At that time he was area representative and member of the board of directors of the Hospital Council of Southern California. Mr. Hoppe is survived by his wife, Sarah, and three daughters.

WHEN INCREASED INTRACRANIAL PRESSURE IS A PROBLEM...

UREVERT™

(LYOPHILIZED UREA AND TRAVERT®)

DECOMPRESSION

LEFT FRONTAL LOBE OSTEOPLASTIC CRANIOTOMY FOR OLIGODENDROGLIOMA*

ABOVE: The effect of 1 Gm. of intravenous urea (3 cc. of Urevert) per kg. of body weight. The cortex lies well below the dura. Pressure is relieved. Visualization and space for manipulation are improved.

BELOW: Same as above – The effect of 1.5 Gm. of urea/kg. of body weight. Brain shrinkage is even greater as evidenced by increased exposure of the sphenoid ridge.

Reduces Danger

Facilitates Operation

Controls Secondary Edema

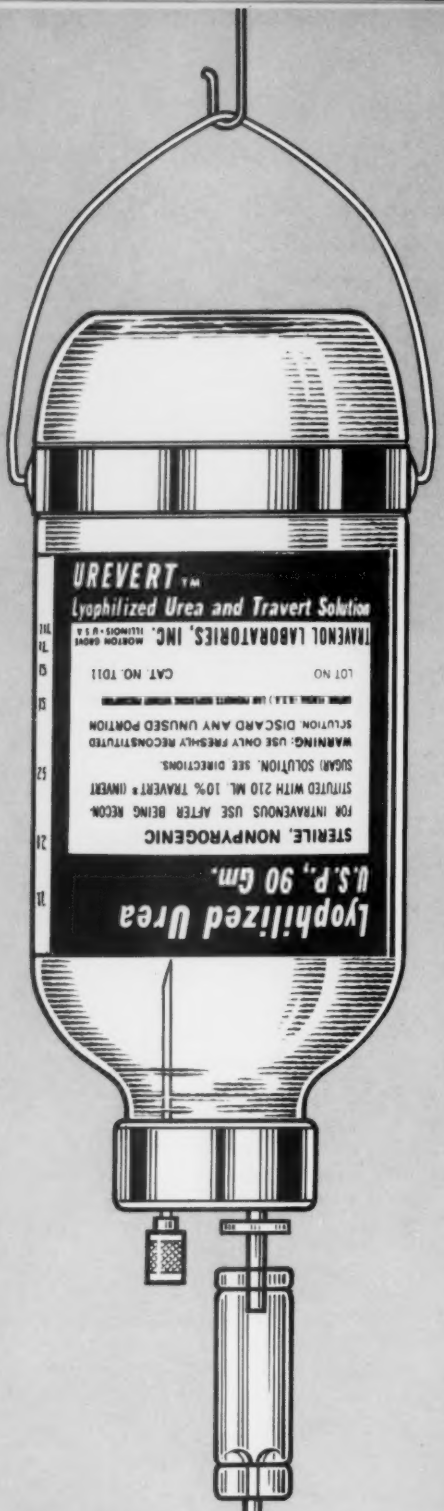
*From the sound-color film "A New Approach to the Reduction of Intracranial Pressure with Urea-Invert Sugar (Urevert)."

TRAVENOL LABORATORIES, INC.

Morton Grove, Illinois

pharmaceutical products division of

BAXTER LABORATORIES, INC.



UREVERT™

"...A HIGHLY USEFUL AND SAFE AGENT FOR REDUCING INTRACRANIAL AND INTRAOCULAR PRESSURE."*

In depressed skull fracture or when intracranial pressure is acute Urevert may be lifesaving. Its use often may facilitate neurologic examination and ease surgical intervention. Postoperatively, Urevert is especially indicated on the second or third day for secondary edema of the brain.

RECOMMENDED DOSAGE:

1 Gm. to 1.5 Gm. of urea per kilogram of body weight. 1 Gm. of urea is present in 3 cc. of Urevert. An indwelling catheter is inserted before treatment. Injection is made intravenously at approximately 60 drops per minute. Reduction of pressure is most pronounced within an hour and persists for three to ten hours.

Complete information on the use of Urevert is available from the Medical Department, Travenol Laboratories, Inc., Morton Grove, Ill.

*Javid, M.: Urea – New Use of an Old Agent, Reduction of Intracranial and Intraocular Pressure, S. Clin. North America *38*:907 (Aug.) 1958.

TRAVENOL LABORATORIES, INC.

pharmaceutical products division of

BAXTER LABORATORIES, INC.

Morton Grove, Illinois

HOSPITAL APPEALS SUSPENSION—

Pharmacy Board Rules on 'Substitution'

The chief pharmacist of a Pennsylvania hospital, whose license had been suspended on a charge of "substitution" of medication, awaits a court hearing expected to be the next step in a year-long dispute. In the meantime, the pharmacist remains in his capacity with the hospital pending further action.

The license of Joseph V. D'Ambola was suspended by the State Board of Pharmacy in June, almost a year after two alleged incidents of "substitution" at Hahnemann Medical College and Hospital of Philadelphia. The board also refused to issue a pharmacy permit to the hospital as long as Mr. D'Ambola remained as pharmacy manager.

The board action grew out of a complaint by Schering Corporation that on two occasions in June 1958 Mr. D'Ambola had substituted "Prednisone" for "Meticorten", a Schering product, and that he had labeled the medication containers "Meticorten."

The two incidents involved a physician, a staff member of the hospital, and a physiology student studying in the hospital's physiology department. A verbal prescription for "Meticorten" was given to the physician by his attending specialist, also a staff member of the hospital; and a written prescription was given to the student by the doctor in charge of student health facilities.

Since the hospital pharmacy did not stock "Meticorten," the chief pharmacist in one instance and his assistant in the other explained that "Prednisone" was generically similar; they dispensed it instead. On the student's medication container, a printed and typewritten label containing the words "Meticorten, 5 mg." was placed; on the physician's container, written in ink, the words "Meticorten (Prednisone) 5 mg." appeared.

SCHERING TAKES ACTION

Later, a Schering Corporation representative saw both containers and their labels and the remains of the tablets dispensed by the pharmacists. He identified the tablet remains as not a Schering product and, after discovering that the prescriptions originally called for "Meticorten," turned the containers and the tablet remains over to his sales manager. Subsequently, Schering's director of professional and trade relations called on Mr. D'Ambola to discuss the "substitution." Still later, Schering Corporation placed a charge of "substitution" against the chief pharmacist with the State Board of Pharmacy.

BOARD'S FIRST HEARING

The first hearing of the board was held December 8, 1958, to determine whether or not "under the established facts and the law applicable thereto, the respondent (D'Ambola) has been guilty of any violation of the provisions of Section 6 of the Act of May 17, 1917, P.L. 208 as amended."

At this hearing, Schering Corporation charged Mr. D'Ambola with two incidents of "substitution" of a generic drug for a brand name drug prescribed by two physicians; and with violation of the applicable section of the State Pharmacy Act.

At this hearing also, Mr. D'Ambola and Charles S. Paxson Jr., administrator of Hahnemann Hospital, denied that the pharmacist's acts were "substitution" because (1) he and his assistant had explained to both the physician and the student that the drug given them was not "Meticorten" but "Prednisone"; and (2) he was acting in good faith because the Hahnemann Hospital formulary permitted him to fill the prescriptions in this way. All staff physicians at the hospital had agreed to use of the formulary when they had signed the hospital's bylaws; therefore, the prescribing physicians had prior knowledge of the alleged "substitution."

THE HOSPITAL'S DEFENSE

In February 1959, the hospital filed a brief on behalf of Mr. D'Ambola with the State Board of Pharmacy. The hospital in its brief contended that Mr. D'Ambola did not violate the State Pharmacy Act of 1917 because (1) he had told the physician that the pharmacy did not stock "Meticorten"; therefore, the physician agreed to accept "Prednisone"; (2) he did not even know that his assistant had filled the student's prescription for "Meticorten" with "Prednisone"; further, the prescribing physician in this case had previously consented to this by agreeing to the formulary; and (3) the Act requires only a general consent and not a specific consent to the filling of any particular prescription.

After this hearing, the board referred the entire matter to the Pennsylvania State Department of Justice for an advisory opinion by the attorney general that would interpret the applicable statutory language.

SUSPEND PHARMACIST'S LICENSE

Last June, Mr. D'Ambola received notice from the State Board of Pharmacy that his license would be suspended for 90 days beginning July 15, 1959. At the same time, Hahnemann Hospital received notice that its pharmacy permit would not be renewed while Mr. D'Ambola remained as pharmacy manager.

On June 30, 1959, Hahnemann Hospital filed an appeal from the State Board of Pharmacy *Adjudication and Order* in the Dauphin County Court. The hospital also secured supersedeas of the appeal over the *Adjudication and Order*, which resulted in issuance of its annual pharmacy permit and suspension of the board's action with respect to Mr. D'Ambola. A further hearing is to be held later this year, but no date has yet been set.

In the meantime, a special committee of the American Society of Hospital Pharmacists met to decide what course of action it should follow. This committee made the following recommendations which

were accepted by the executive committee of the society:

(1) Engage legal counsel to advise the society and other organizations regarding the hospital formulary system, insofar as the above case involves the formulary system.
(2) Refrain from entering the issue at present at the national level.
(3) Retain counsel for the society to study the Hahnemann Hospital formulary issue. ■

AT CHICAGO CONVENTION—

Osteopaths Vote to Remain Independent; Rebuff AMA Resolution on D.O. Colleges

The House of Delegates of the American Osteopathic Association has voted 95 to 22 to remain apart from organized medicine.

This resolution was adopted during the 63rd annual convention of the AOA in Chicago in mid-July. It answered AMA action the month before on its policy toward osteopathy and osteopathic physicians. The AMA House of Delegates declared at that time it is not unethical for doctors of medicine to teach in osteopathic colleges provided they are "in process of being converted to approved medical schools under the supervision of the AMA Council on Medical Education and Hospitals."

The immediate past president of AOA, Dr. George W. Northup of Morristown, N. J., pointed out that this AMA stipulation would bring osteopathic colleges under AMA supervision, and said, "This is too great a price to pay for acceptance."

OSTEOPATHS COMMENT ON AMA STAND

A number of speakers at the AOA convention voiced comments that related to the AMA resolutions.

"Far too many people believe that the osteopathic profession wants to be absorbed into the AMA," said Dr. Northup.

Commenting on the AMA action toward appointment of a liaison committee, if mutually agreeable, to consider problems of common concern, Dr. Northup pointed out that the AOA has had a liaison or conference committee since 1952. However, he said that AOA is not unwilling to meet with an AMA liaison committee.

"We must make crystal clear to all that we are not interested in amalgamation or merger with the AMA and that we are only interested in maintaining ourselves as a complete school of medicine," was the comment of Dr. Robert D. McCullough of Tulsa, Okla., a former AOA president.

Dr. Otterbein Dressler, Detroit, said he believed that the "wholesome competition" offered by osteopathic doctors to organized medicine was "beneficial to the entire nation. We have provided a way for many more doctors to serve than the nation could have had without us," he said.

The AOA's board of trustees and house of delegates also considered such subjects as interprofessional relationships, hospital standards, and health payment plans.

ELECT OFFICERS

Dr. Galen S. Young of Chester, Pa., was installed as president at the July meeting of AOA. Dr. Roy J. Harvey of Midland, Mich., was chosen president-elect. Other officers elected were: first vice president, Dr. Wesley B. Larsen of Hinsdale, Ill.; second vice president, Dr. J. Mancil Fish of Tulsa, Okla.; third vice president, Dr. James H. McCormick of Elkhart, Ind. ■

State Legislation Affecting Osteopaths

During his convention speech, Dr. George W. Northup, immediate past president of the American Osteopathic Association, reported that in 19 states single licensing boards now pass on all candidates for healing arts licensure.

Summarizing the current legal status of osteopathy, the association reported that in 36 states, District of Columbia and Hawaii, osteopathic physicians are under law eligible to receive licenses granting unlimited practice rights. In 12 states, certain limitations exist as to D.O.'s rights to prescribe drugs and/or prohibiting them from the use of major surgery.

ILLINOIS LEGISLATION

This year the osteopaths made legislative gains in two states. The new Illinois law was announced at the convention. It provides that all of the state's 350 osteopathic physicians will be eligible to practice complete medicine and surgery after completing a 248-hour refresher course to acquaint them with recent developments in areas where they have been restricted in practice, and after taking a license examination. Prior to this law, and since 1950, only graduates of the Chicago College of Osteopathy had been eligible for unlimited licenses.

The new statute also added a doctor of osteopathy and a doctor of chiropractic to the five medical doctors on the state board of medical examiners. An osteopathic physician has acted as a nonvoting advisor to the board for a number of years.

MISSOURI PRACTICE ACT

Missouri has a new Medical Practice Act which affects osteopaths. Passed after considerable debate, this legislation provides for a single board to examine and register doctors of medicine and osteopaths.

The seven-member State Board of Registration for the Healing Arts will comprise five M.D.'s and two D.O.'s. Candidates for a license will take the same examinations regardless of the kind of school in which they were trained. They will use the initials M.D. or D.O., depending upon the school they attended.

Under the new statute, doctors must re-register each year. Registration fees are intended to finance the activities of the board.

Provisions contained in prior drafts of the bill, which might have been interpreted adversely to the interests of Missouri hospitals, were eliminated during the legislative history of the measure. ■

Hospital Management Men

Before you dismiss "office automation" as too costly and complex...read this!

Today, automation in the office is the subject of hot debate. To many hospital administrators and comptrollers it means a mass of complicated machinery and the highly-trained personnel to run it. To others, it means excessive training and indoctrination, an inordinate outlay of cash, an end to time-tested methods of operation.

Yet most hospital management men agree that today, in the face of ever-increasing costs, what they *need* are the faster, more accurate facts and figures that office automation can deliver – the up-to-the-minute facts and figures on revenue, patient days, service-department utilization that contribute so greatly to better patient care. But, they ask, how do we get them without undue cost and complexity?

The answer is with new Keysort machines and methods.

Why Keysort? Because Keysort, alone, is reducing the cost and complexities of modern office automation with a highly-flexible system that fits easily into your existing operations.

Result: Keysort is today cutting paper-work down to size.

Keysort procedures are so simple that they can be handled completely by your present staff. Basic data on Keysort Requisition-Charge Tickets is simultaneously notched and imprinted with the Keysort Data Punch for fast, easy classification. Complete and automatic processing is provided by the Keysort Tabulating Punch which punches, adds and totals quantities and amounts. Original records can now be processed automatically to produce desired reports – *on time.*

New Keysort machines and methods today offer you the simplest means of instituting the *practical* modern office automation which can speed to your desk the on-time reports that aid you in providing better patient care. With little or no change in your present methods. Without the need for specialized personnel. And at remarkably low cost.

Contact your nearby Royal McBee Data Processing Representative, or write Royal McBee Corporation, Hospital Division, Port Chester, N. Y. for illustrated Brochure S-442.

ROYAL McBEE · *data processing division*

NEW CONCEPTS IN PRACTICAL OFFICE AUTOMATION

AFTER BLUE CROSS RATE HEARING—

Maryland Legislative Committee Launches Hearings on Hospital Costs, Overuse

A special committee appointed by the Maryland legislature opened a broad study of hospital costs last month on the heels of a Blue Cross rate increase hearing at which the insurance commissioner said he did not have jurisdiction over hospital costs.

The legislative study was authorized more than a month before the series of hearings began on July 28. The committee, headed by Sen. John C. North of Talbot County, is a unit of the legislative council of Maryland, a body of legislators which makes various studies while the legislature is not in session and then makes recommendations to the legislature for action.

Chairman North said the hearing would cover questions of quality of medical care; it would consider whether hospitals that received Blue Cross payments should be classified for benefit level according to size, and whether extravagance and excessive hospitalization have been factors in rising premium rates.

The first testimony was given to the legislators by Reginald H. Dabney, executive director of the Maryland Hospital Service Plan (Blue Cross). He described the operation of the plan, its relationship with hospitals and the reasons for the request for another rate increase.

The committee quizzed Mr. Dabney at length following his testimony, asking him what had been done about the recommendations made by the previous insurance commissioner after the 1958 rate hearings; what controls Blue Cross exerted to insure efficiency of hospital operation, over potential abuse and excessive stay and over excessive services and diagnostic stays. The committee then asked Mr. Dabney to return for further testimony on August 4.

The legislators seemed especially interested in the utilization story. Throughout their questioning of Mr. Dabney, they questioned the necessity of all cases of hospitalization and asked if some stays were unnecessarily long and others were for diagnostic purposes.

The first hospital administrator to testify, Russell A. Nelson, M.D., director of the Johns Hopkins Hospital, was due to appear before the legislators on August 4.

COMMISSIONER LIMITS HEARING SCOPE

The hearing before the insurance commissioner on the plan's request for an average increase of 24.5 per cent in its standard contract rates, effective October 1, was expected by some to develop into the sort of free-wheeling investigation now underway by the legislative group.

The commissioner, F. Douglass Sears, nipped that in the bud. He said at the outset of the hearing which began on July 15 that "It is not my purpose here nor do I understand it to be the function of the insurance commissioner, to conduct a general investigation into the future of nonprofit health service plans in this state. If a broad, over-all investigation of such plans and of the hospital

On our floor
THIS INCERT® SYSTEM IS JUST ABOUT THE MOST! LOOK. . . IN AN EMERGENCY, WE CAN ADD MEDICATION TO SEVERAL DIFFERENT SOLUTIONS IN LESS THAN A MINUTE!
IT'S FOOLPROOF, TOO. BY LEAVING THE INCERT VIAL IN NECK OF BOTTLE UNTIL READY FOR USE— THERE'S NO POSSIBILITY OF MISIDENTIFICATION.
. . .AND NO MORE NEEDLES, SYRINGES OR AMPULES TO BOTHER WITH. SAVING ALL THAT PREPARATION TIME IS REAL ECONOMY.
TRAVENOL LABORATORIES, INC. Morton Grove, Illinois

service and costs thereunder is necessary and desirable, I am sure it will be forthcoming, as evidenced by the commendable interest expressed by members of the legislature and other public officials. For the present, I must confine this hearing to the application before me and I must be guided by the law as it now exists."

The commissioner said that he had been advised by the attorney general that he was not required by law to permit oral cross examination of witnesses and announced that he did not intend to permit it.

In a subsequent statement, Commissioner Sears said, "I want to make my position clear on the matter of the cost of hospital operation and services. I do not reverse the former commissioner's statement of last year that this is a matter germane to the whole problem of nonprofit plans. My position is that the insurance commissioner has no control or jurisdiction over hospitals and, therefore, this is not the proper forum to which arguments on this problem should be addressed."

His denial of the right to open cross-examination was bitterly attacked at the hearing. An attorney for a group of Blue Cross subscribers called Mr. Dabney to the stand as his own witness, thus attempting to get around the no cross-examination ruling. However, the commissioner stopped several lines of questioning. Attorneys for the Maryland radiological and pathological societies said that, "the limitations imposed on this hearing make our participation unnecessary and useless. We had intended to prove that the current practices of Blue Cross in the area of x-ray and pathology examinations increase the use of hospital facilities and thus are an important cause in the proposed increase in subscription rates.

Joseph Sherbow, an attorney for the Maryland Hospital Council, said that hospitals were perfectly willing to explain the "wonderful" progress in hospitals and the "advances made in hospital management" before the proper tribunal. At that time he said, hospitals "will not take the role of defendants but will rather . . . proudly portray what they are doing and what they have done for Marylanders."

In his testimony, Mr. Dabney said that the plan was in a precarious financial condition and that "Blue Cross, without prompt approval of its request, faces insolvency." ■

New Postage Law Reduces Charge on Specimens

A reduction in the minimum third class postage charge on odd shaped containers has been announced by the United States Post Office, following congressional action.

This regulation includes all cylindrical shaped containers of blood, urine and other types of specimens mailed by physicians to hospitals, clinics and health departments for analysis.

Effective last month, a reduced minimum rate of 3½ cents applies on all such containers that weigh two ounces or less. The former minimum postage was 6 cents.

Specimen mailings may be made at regular third class rates. However, although the normal rate of 3 cents would be charged for a two-ounce piece of regular third class mail, a minimum charge of 3½ cents applies if the piece of mail is of an odd shape or form.

The Post Office further states

Write for sample unit.

TIME ISN'T ALL YOU SAVE — THINK OF THE ACTUAL DOLLAR SAVINGS IN EQUIPMENT COST AND MAINTENANCE.
. . . . PLUS THE EXTRA HOURS IT GIVES US FOR NURSING CARE.
WISH I HAD HALF THE MONEY THIS HOSPITAL HAS SAVED SINCE WE STANDARDIZED ON INCERT.
Trav

***Pharmaceutical Products Division of* BAXTER LABORATORIES, INC.**

that "hospitals . . . to which such materials are sent will not pay postage due on specimens sent to them for analysis." ■

New Wisconsin Law Allows Hospital-M.D. Contracts

New legislation regulating contractual agreement practices between hospitals and specialists has been enacted in Wisconsin. The new statute also concerns methods of billing for specialists' services.

The new law does not call for any major changes in existing hospital practices, but it clarifies certain disputed points. It parallels in principle the attorney general's interpretation of the present state statutes. His opinion was rendered last June at the state assembly's request.

This legislation was for many months the cause of dispute between the hospital and medical groups in the state. It was enacted rapidly after the Wisconsin Hospital Association and the State Medical Society of Wisconsin reached a compromise on the bill's wording.

The amended statute, which will take effect Jan. 1, 1961, states that "it is lawful for a physician to contract with a hospital to provide consultation services for attending physicians . . . Any treatment by such a consultant shall be in his capacity as a private practitioner; and such treatment shall be rendered only at the request of the attending physician, except that a physician specializing in pathology, physical medicine or radiology may include the treatment of referred cases in his contract with a hospital."

CONTRACT STIPULATIONS

Regarding hospital-specialist contracts, the statute further provides that—

- Such physician must be a member of, or acceptable to, the medical staff of such hospital.
- Relationship between hospital and physician must not be that of employer and employee.
- Physician's professional judgment will be free from supervision or interference by the hospital.
- Physicians will not be salaried.

Regarding billing practices, the new statute authorizes hospitals to bill for services of physicians "if agreeable to the contracting parties." However, the statement to the patient must indicate that the services of such physicians, designated by name, are included in the departmental charges.

The original bill, sponsored by the state hospital association, did not provide for segregation of service charges in the hospital statement.

PERMITS PHYSICIAN PARTNERSHIPS

The Wisconsin legislation permits partnerships among physicians and single billing in the name of such partnership.

To prohibit fee splitting between "physicians and others," the statute provides that a physician who renders any service or assistance to any patient, physician, corporation or other institution, including a hospital, must bill the patient directly.

The statute, however, allows hospitals to employ interns and residents on salary. ■

1959 hospital administrative residents

Following is a listing of students who have completed their classroom work in hospital administration and been assigned to residencies. This is a continuation of a listing begun in the July 16 issue of this Journal.

GEORGIA STATE COLLEGE

Course director: Henry C. Pepper

DEXTER, WILLIAM H., to Millard L. Wear, Kennestone Hospital, Marietta, Ga.

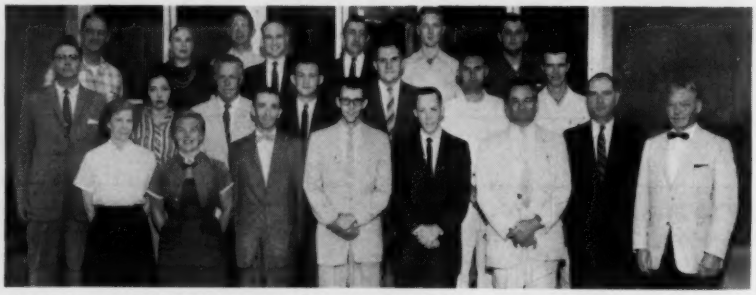
HAMER, CLIFFORD E., to Robert Murphy, Floyd Hospital, Rome, Ga.

HENDRICKS, WILLIAM H., to A. A. Rosser Candler Hospital, Savannah, Ga.

LEAMAN, W. H., to J. W. Fetterman, Pineview General Hospital, Valdosta, Ga.

MITCHELL, F. G., to Millard L. Wear, Kennestone Hospital, Marietta, Ga.

PARKER, HENRY VIRGIL, to Oscar S. Hilliard, John L. Hutcheson Me-



GEORGIA STATE COLLEGE OF BUSINESS ADMINISTRATION class of 1958-59: (from left) front row: Elsie M. Shirley; Clara Juanita Jones; Willis H. Jenkins; W. H. Leaman; George E. Thomas; Millard L. Wear (instructor); Archie G. Rich; Henry C. Pepper; (course director). Second row: James Milton Stewart; Maria Porras; Clayton E. Alexander; Richard K. Welch; Damon D. King; Theodore E. Barner; Turnstill O. Presley. Third row: Floyd G. Mitchell; Thelma Van Norte; Ralph Lee Travis; William Hendricks; Clifford Hamer; Donald E. Tate; Sherwin Z. Goodblatt. Not shown: Victor R. Deeter; Henry Virgil Parker; William B. Stalvey; Mary Gill Smith.

STATE UNIVERSITY OF IOWA residents are, (from left) top row: Capt. George F. Allen; Richard H. Stenner; Howard A. Walker; John L. Garrett; Larry W. Pugh; John P. Richwagen; Donald D. Washburn. Center row: Dennis Q. Opheim; Wilfred F. Loebig; Jacque R. Larson; Gerald R. Dokka; Salvo A. Mudano; Gilbert R. Lubbers; James E. Moon. Seated: William A. McLees (professor); Gerhard Hartman (course director); Leon I. Gintzig (professor).

morial Tri-County Hospital, Fort Oglethorpe, Ga.

PORRAS, MARIA, to William A, Barrett, Athens (Ga.) General Hospital.

PRESLEY, T. O. JR., to Millard L. Wear, Kennestone Hospital, Marietta, Ga.

STEWART, JAMES M., to Dr. J. A. Thrash, Medical Center, Columbus, Ga.

TATE, DONALD E., to J. R. Griffith, Macon (Ga.) Hospital.

THOMAS, GEORGE E., to E. M. Rogers, Casualty Hospital, Washington, D.C.

WELCH, R. K., to J. R. Griffith, Macon (Ga.) Hospital.

STATE UNIVERSITY OF IOWA

Course director: Gerhard Hartman, Ph.D.

ALLEN, CAPT. GEORGE F. (USAF), to Maj. Kenneth H. Long, USAF Hospital, Maxwell Air Force Base, Montgomery, Ala.

DOKKA, GERALD R., to Roland B. Enos, Schoitz Memorial Hospital, Waterloo, Iowa.

GARRETT, JOHN L., to Harold R. Heberlein, Jackson Clinic, Madison, Wis.

LARSON, JACQUE R., to Robert G. Boyd, Morristown Memorial Hospital, Morristown, N. J.

LOEBIG, WILFRED F., to Donald F. Plunkett, Mercy Hospital, Council Bluffs, Iowa.

LUBBERS, GILBERT R., to Lester E. Richwagen, Mary Fletcher Hospital, Burlington, Vt.

MOON, JAMES E., to Joseph K. Owen, Ph.D., District of Columbia General Hospital, Washington.

MUDANO, SALVO A., to Dr. Leland E. Stilwell, Veterans Administration Hospital, Iowa City, Iowa.

OPHEIM, DENNIS Q., to John F. Latcham, Trumbull Memorial Hospital, Warren, Ohio.

PUGH, LARRY W., to Louis B. Blair, St. Luke's Methodist Hospital, Cedar Rapids, Iowa.

RICHWAGEN, JOHN P., to Oliver G. Pratt, Rhode Island Hospital, Providence.

STENNER, RICHARD H., to Vernon T. Spry, Methodist Hospital, St. Louis Park, Minn.

WALKER, HOWARD A., to Fred R. Higginbotham, Baptist Memorial Hospital, San Antonio, Tex.

WASHBURN, DONALD D., to Dr. Harold M. Coon, Milwaukee County Hospital, Milwaukee.

SAINT LOUIS UNIVERSITY

Course director: Charles E. Berry

ALBERS, SISTER M. AMBROSE, O.S.F., to Sister M. Regula, F.S.P.A., St. Francis Hospital, LaCrosse, Wis.

BIERSCHBACH, SISTER M. VIVIAN, O.S.B., to Sister Grace Marie, S.C., administrator, St. Mary's-Corwin Hospital, Pueblo, Colo.

BOLTON, SISTER RUTH MARIE, O.S.F., to Sister M. Ursula, C.S.A., administrator, St Vincent Charity Hospital, Cleveland.

BRAKE, SISTER M. HILDALITA, Ad. PP.S., to Sister M. Vincent, C.C.V.I., administrator, Santa Rosa Hospital, San Antonio, Tex.

BRAUN, SISTER JEANNE MARIE, S.C.S.C., to Sister M. Rosaria, O.S.B., administrator, Sacred Heart Hospital, Yankton, S.D.

BUCKLEY, SISTER MARY ASSUMPTA, R.S.M., to Sister M. Stephanie, administrator, Loretto Hospital, Chicago.

BUNKER, ANTHONY LOUIS, to City Hospital, St. Louis.

For a Handy Purchasing Reference

see the

GUIDE FOR HOSPITAL BUYERS

on the Goldenrod pages

Part II of the Aug. 1, issue

HOSPITALS

Journal of the American Hospital Association

840 North Lake Shore Drive Chicago 11, Illinois

ST. LOUIS UNIVERSITY residents are, (from left) front row: Anthony Bunker; Joseph Karonovich; Paul R. Donnelly (instructor); McAllen, Daniel Lawrence Jr.; Luther Ihle; Sister M. Magdalen Murphy; Sister Peter Mary Cabrey, C.R.S.M.; Sister Mary Regis Waszak, C.S.S.F.; Sister Joanna; Sister Jeanne Marie Braun, S.C.S.C.; Sister Philomene Ihle, Ad.PP.S.; Sister M. Fridoline Multhaup, C.S.F.; Sister Regina Mary Hanon, C.R.S.M.; Sister M. Weneburga Kaeuper, M.S.C.; Sister M. Helen Louise Deeken, S.S.M.; Sister Marie de Pazzi Lunch, C.S.J.; Sister M. Canisia Gerlach, O.S.F.; Sister Maureen McDonald, R.S.M.; Sister Anne Mary O'Donnell, S.C.; Sister M. Ambrose Albers, O.S.F.; John Charles McAvinn; John Homjak; Charles E. Berry (course director). Second row: Sister Angela Clare Moran, C.C.V.I.; Sister Mary Assumpta Buckley, R.S.M.; Sister Mary Patrice Sinnott, R.S.M.; Sister Alma Corde Schnellinger, O.P.; Sister Mary Thomas Jirauch, C.D.P.; Sister M. Hildalita Brake, Ad.PP.S.; Sister Peter Claver Thomas, F.C.S.P.; Sister Maria of Providence Moran, F.C.S.P.; Sister Ruth Marie Bolton, O.S.F.; Sister M. Fabiola Buescher, P.H.J.C.; Sister M. Leonoris Henke, P.H.J.C.; Sister M. Vivian Bierschbach, O.S.B.; Sister Mary Baptist Simon, R.S.M.; Sister Mary Laura Gunn, R.S.M.; Sister Verenice Mary McQuade, S.S.J.; Paul Arthur Irwin.

CABREY, SISTER PETER MARY, C.R.S.M., to Sister M. Loretto Bernard, S.C., administrator, St. Vincent's Hospital, New York.

DEEKEN, SISTER M. HELEN LOUISE, S.S.M., to Sister Marie Charles, administrator Good Samaritan Hospital, Dayton, Ohio.

GERLACH, SISTER M. CANISIA, O.S.F., to Sister M. Loretto Bernard, S.C., administrator, St. Vincent's Hospital, New York.

GUNN, SISTER MARY LAURA, R.S.M., to Sister M. Wilhelmina, O.S.F., administrator, St. Joseph's Hospital, Syracuse, N.Y.

HANLON, SISTER REGINA MARY, C.R.S.M., to Sister M. Loreto, S.P., administrator, St. Vincent Hospital, Worcester, Mass.

HENKE, SISTER M. LEONORIS, P.H.J.C., to Sister Denise, administrator, Providence Hospital, Detroit.

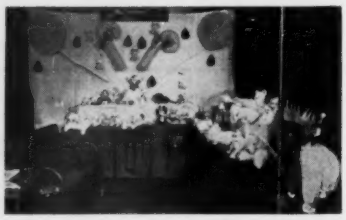
HOMJAK, JOHN, to Methodist Hospital, Memphis, Tenn.

IHLE, LUTHER, to Sister Mary Maurita, R.S.M., St. Mary's Hospital, Grand Rapids, Mich.

IHLE, SISTER PHILOMENE,

TYKIE TOYS PUTS THE "FUN" IN "FUND" RAISING!!

You're most welcome at our Booth 2135, A.H.A. National Convention, N.Y.C., August 24-27. (Across from Auxiliary Booth)



You'll want to see many new designs: Musical Toys, Bottle Holders, Laundry Bags, Hand Puppets, Soft Cuddly Toys.

FOAMAGIENIC® *Soft Toys for Impulse Sales.*

SELL ALL YEAR 'ROUND!
You can add $ to your funds, *now!*
Send for Catalog of "50 Fund Raisers."

TYKIE TOY, INC. Dept. H-8-59 CONLEY, GEORGIA

YOU SAVE money for your hospital when you buy Gudebrod silk and cotton sutures.

Sterilize Gudebrod sutures as you need them and save **UP TO 50%** of your suture **COST.** Every improvement **IN** non-absorbable sutures is incorporated in these **SUTURES . . .** manufactured by Gudebrod for eighty-nine years.

Reduce costs **WITH** no sacrifice in quality. Buy **GUDEBROD** and save. Write for the Gudebrod story, "How You Can Save up to 50% of Your Suture Cost."

Gudebrod BROS. SILK CO., INC.

Surgical Division: 225 West 34th St., New York 1, N.Y.
Executive Offices: 12 South 12th St., Philadelphia 7, Pa.

CHICAGO BOSTON LOS ANGELES

Ad.PP.S., to Sister M. Regula, F.S.P.A., administrator, St. Francis Hospital, LaCrosse, Wis.

IRWIN, PAUL, to Mrs. E. S. Todd, administrator, Little Company of Mary Hospital, Evergreen Park, Ill.

JIRAUCH, SISTER MARY THOMAS, C.D.P., to Sister M. Rosaria, O.S.B., administrator, Sacred Heart Hospital, Yankton, S. D.

KAEUPER, SISTER M. WENEBURGA, M.S.C., to Sister Eugene Marie, S.C., administrator, Good Samaritan Hospital, Cincinnati.

KARONOVICH, JOSEPH, to Sister Marybelle, O.S.B., administrator, St. Mary's Hospital, Duluth, Minn.

LUNCH, SISTER MARIE DE PASSI, C.S.J., to Sister Louise Anthony, administrator, Hospital of St. Raphael, New Haven, Conn.

MCALLEN, DANIEL LAWRENCE JR., to Chanute Air Force Base, Rantoul, Ill.

MCAVINN, JOHN, to Jack Harrison, administrator, Lynn (Mass.) Hospital.

MCDONALD, SISTER MAUREEN, R.S.M., to Sister Mary Maurita, R.S.M., administrator, St. Mary's Hospital, Grand Rapids, Mich.

MCQUADE, SISTER VERENICE MARY, to Sister Miriam Dolores, C.S.C., administrator, Mt. Carmel Hospital, Columbus, Ohio.

MORAN, SISTER ANGELA CLARE, C.C.V.I., to Sister Anna Marie, administrator, St. Vincent's Hospital, Erie, Pa.

MORAN, SISTER MARIA of PROVIDENCE, F.C.S.P., to Sister Ellen Patricia, S.C., administrator, St. Elizabeth's Hospital, Elizabeth, N.J.

MULTHAUP, SISTER M. FRIDOLINE, O.S.F., to Sister Ellen Patricia, S.C., administrator, St. Elizabeth's Hospital, Elizabeth, N.J.

O'DONNELL, SISTER ANNE MARY, S.C., to Sister M. Visitation, C.S.J., administrator, St. Mary's Hospital, Waterbury, Conn.

SCHNELLINGER, SISTER ALMA CORDE, O.P., to Sister Margaret, D.C., administrator, Carney Hospital, Boston.

SIMON, SISTER MARY BAPTIST, R.S.M., to Sister Bernard Mary, C.S.J., administrator, St. Francis Hospital, Hartford, Conn.

SINNOTT, SISTER MARY PATRICE, R.S.M., to Sister Bernard Mary, C.S.J., administrator, St. Francis Hospital, Hartford, Conn.

THOMAS, SISTER PETER CLAVER, F.C.S.P., to Sister M. Alma, O.S.F., administrator, St Elizabeth's Hospital, Brighton, Mass

WASZAK, SISTER MARY REGIS, C.S.S.F., to Sister M. Bernardine, S.P.S.F., administrator, St. Elizabeth's Hospital, Dayton, Ohio.

Book reviews

(Continued on page 66)

tion, conducted a study that resulted in this publication.

The volume includes a wealth of information so that communities and organizations looking forward to new and expanding rehabilitation centers may have the benefits of the experience that has been accumulated.

The book includes information about rehabilitation center operations: physical plant, financial structures and methods of meeting community needs. At the time of the study there were around 100 rehabilitation centers in the United States, all varying in size, program and philosophy. Rehabilitation centers are not and probably will

yes, they're actually
DISPOSABLE

new Perry disposable
(PATENT PEND.)
SURGEONS' LATEX GLOVES

Now save time and money at the drop of a glove. Perry disposable surgeons' latex gloves are priced low enough to be disposable, saving the cost of reconditioning gloves and the time of laundry personnel and nurses. No more washing, sorting, testing and packing for autoclaving.

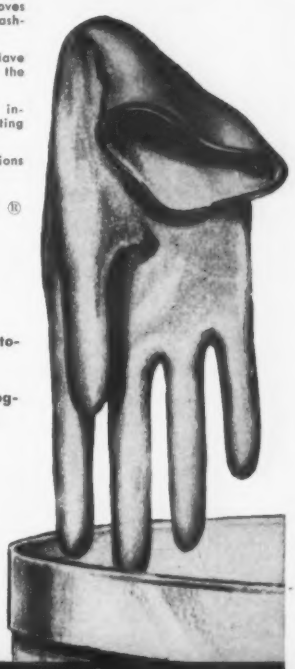
Just sterilize Perry disposable gloves in their autoclave package (with autoclave-indicator tape). Use them with the full protection of new gloves* and throw them away.

White or brown latex. Full range of sizes, 6 through 9 including half sizes. BIO-SORB (R) biologically absorbable dusting powder included.

*Perry disposable latex gloves meet government specifications ZZ-G-421, Amendment 4.

EASY-OPEN AUTOCLAVE PERRY-PACK ®

- Ready for autoclaving.
- Tear open from top after autoclaving.
- "Scotch" brand hospital autoclave tape on package.
- Packet of BIO-SORB (R) biologically absorbable dusting powder in cuff.



SALES REPS.
W. A. BUSHMAN ASSOCIATES, Inc.
1841 Broadway
NEW YORK 23, N. Y.
BIO-SORB DUSTING POWDER IS A T.M. OF ETHICON, INC.

For Samples and Further Information WRITE DEPT. H-859

Perry RUBBER COMPANY
MASSILLON, OHIO

© 1958

never be standardized, and any attempt to define what is and what is not a rehabilitation center would lead to fruitless discussion.

The volume is in three parts:

Part one gives an over-all view of rehabilitation philosophy, services, numbers and types of patients, objectives, and poses some 15 questions that need answers.

Part two reports on 65 general rehabilitation centers, 20 independent centers with beds, 31 independent centers without beds and 14 hospital centers.

Part three includes descriptions of 77 rehabilitation centers.

This volume should be of great assistance to any community, hospital or group contemplating development of new or expansion of existing rehabilitation services.—HARLAN E. LANCE, *business administrator, Rehabilitation Institute of Chicago.*

Hospital association meetings

(Continued from page 6)

14-15 Vermont Hospital Association, Montpelier

14-16 Saskatchewan Hospital Association, Saskatoon (Bessborough Hotel)

15-16 Nebraska Hospital Association, Lincoln (Cornhusker Hotel)

15-16 Wyoming Hospital Association

19-20 Idaho Hospital Association, Boise (Elks Lodge)

19-20 Oregon Association of Hospitals, Coos Bay

19-22 **Staffing Departments of Nursing,** Minneapolis (Radisson Hotel)

19-23 ***American Occupational Therapy Association,*** Chicago (Morrison Hotel)

19-23 ***American Public Health Association,*** Atlantic City (Convention Hall)

20-21 North Dakota Hospital Association, Minot

20-21 South Dakota Hospital Association, Yankton

20-23 British Columbia Hospital Association, Vancouver (Vancouver Hotel)

20-23 California Hospital Association, Yosemite (Ahwahnee Hotel)

21-22 Washington State Hospital Association, Yakima (Chinook Hotel)

26-28 Maryland-District of Columbia-Delaware Hospital Association, Washington (Shoreham Hotel)

26-28 Ontario Hospital Association, Toronto (Royal York Hotel)

27-29 Associated Hospitals of Alberta, Edmonton (Jubilee Auditorium)

28-30 Missouri Hospital Association, St. Louis (Sheraton-Jefferson)

29-31 West Virginia Hospital Association, White Sulphur Springs (Greenbrier Hotel)

NOVEMBER

2-4 ***Association of American Medical Colleges,*** Chicago (Edgewater Beach Hotel)

2-6 **Hospital Engineering,** Chicago (AHA Headquarters)

4-7 ***American Association of Blood Banks,*** Chicago (Edgewater Beach Hotel)

5-6 Oklahoma Hospital Association, Tulsa (Mayo Hotel)

9-11 **Basic Institute for Directors of Hospital Volunteers,** Chicago (AHA Headquarters)

9-13 **Physical Therapists,** Houston (Rice Hotel)

12-13 Kansas Hospital Association, Kansas City (Town House Hotel)

12-14 Virginia Hospital Association, Old Point Comfort (Hotel Chamberlin)

15-20 ***Radiological Society of North America,*** Chicago (Palmer House)

16-19 **Central Service Administration,** Chicago (AHA Headquarters)

16-20 American Association of Medical Record Librarians, Basic Institute for Medical Record Personnel, Denver (Cosmopolitan Hotel)

Nov. 29-Dec. 2 ***National Society for Crippled Children and Adults,*** Chicago

Nov. 30-Dec. 4 **Dietary Department Administration,** Portland, Ore. (Multnomah Hotel)

DECEMBER

1-3 **Administrator's Secretaries,** Chicago (AHA Headquarters)

3-4 Florida Hospital Association, Jacksonville (Robert Meyer Hotel)

3-4 Hospital Association of Hawaii, Honolulu (Hawaiian Village)

3-4 Illinois Hospital Association, Springfield (Abraham Lincoln)

7-11 **Hospital Design and Construction,** Chicago (AHA Headquarters)

26-31 ***American Association for the Advancement of Science,*** Chicago

Gudebrod

REDUCES

SUTURE

PRICES

as much as

20%

THIS MONTH'S

Super Value

HI-LO EASY CHAIR

With All These Features!

Ⓐ Adjustable Height Back Cushion

Ⓑ Form-Fitting Bent Wood Back Frame

Ⓒ Wall-Saver Design

No. 1082 Easy Chair's back cushion can be used in two positions — with top flush with the chair's back frame, or held 5" higher by means of a novel strap holder. It is ideal for convalescent patients — unmatched in comfort and durability for any use. Spring-filled seat cushion and latex-filled back cushion are removable and upholstered with elastic Naugahyde. Must be seen to be fully appreciated. On display at our showroom — or let us demonstrate in your institution. LOWEST CONTRACT PRICES.

SEND FOR BULLETIN 1082

EICHENLAUBS
Contract Furniture
3501 BUTLER ST., PITTSBURGH 1, PA.
ESTABLISHED 1873

E-34

Service from headquarters

(Continued from page 36)

it is sent to the various departments. An alternate to this method is to have separate carts or portable shelves which may be filled for each floor as the linen comes off the laundry processing line. The latter method has the advantage of eliminating the step of placing the linen temporarily on the central storage room shelves.

In general linen distribution systems fall into three classifications:

1. *The requisition system.* The nurse in charge of the patient floor orders the linen needs directly from the linen supply room. This system requires a record, usually made in triplicate.

2. *The direct exchange system.* Each floor has a quota of linen for its own use. Soiled linen is counted, a record is made and the counted linen is sent to the laundry where an equal amount of clean linen is made up and returned to the proper floor.

3. *Color code system.* Each floor is issued a quota in a specific color identifying that unit. The quota is usually for maximum bed count plus reserve linen for emergencies. This system has the advantage that no daily count is required because all linen which is soiled and received in the laundry may be washed and returned to the floor to which that specific color has been assigned.

For the average size hospital, the colored linen system is probably the easiest to handle and the most economical in the long run.

—G. A. WEIDEMIER

A balanced hospital community

(Continued from page 44)

small—particularly in urban areas—to permit extensive new developments. But the choice of every new site, and the design of every new building, provides an opportunity to enquire whether our ideas about hospitals are commensurate with the needs of the next half century. If we conclude, as I believe we must, that at the present time we are putting a 19th century concept into 20th century buildings, we have no choice but to revise radically our ideas about the hospital centre. Whatever the initial difficulties, I suggest that the development of a balanced hospital community will provide a full reward. For patients, particularly the aged and the mentally ill, it will mean a vast improvement in the standard of care. For administrators it offers the promise of a solution of some of the most intractable problems with which they are confronted. And for medical people it will result in removal of the blinkers which have restricted vision since the late 18th century.

Fifty years ago the Webbs observed that in Great Britain the voluntary hospitals took what was interesting, and the public hospitals were left with what was difficult. Within a balanced hospital community the distinction between the interesting and the difficult would disappear, and for the first time the whole field of institutional medical care would be seen in perspective. ■

REFERENCES

1. McKeown, T. The concept of a balanced hospital community. *Lancet* 1:701 April 5, 1958.
2. Lowe, C. R. and McKeown, T. The care of the chronic sick. I Medical and nursing requirements. *Brit.J.Soc.Med.* 3:110 July 1949.
3. Garratt, F. N., Lowe, C. R. and Mc-

The NEW DUAL PURPOSE
VASELINE
PETROLATUM GAUZE U. S. P.
STERILE
3 x 3 PAD, opens to 3 x 9 INCHES
TEAR HERE
3" x 9" STRIP
Shorter length ends waste on small area wounds. New Z-fold insures perfect graft takes. Guaranteed sterile at time of use.
6th SIZE of VASELINE® PETROLATUM GAUZE
3" x 3" PAD
Three-ply, fine-mesh gauze, lightly impregnated — for use in physician's office, industrial medical department, first aid.
Now supplied in: 1/2"x 72" 3"x 18" 1"x 36" 3"x 36" 3"x 3"/ 3"x 9" 6"x 36"
Sole Maker:
CHESEBROUGH-POND'S INC.
Professional Products Division
New York 17, N. Y.
VASELINE is a registered trademark of Chesebrough-Pond's Inc.

Keown, T. Institutional care of the mentally ill. *Lancet* 1:682 March 29, 1958.
4. Garratt, F. N., Lowe, C. R. and McKeown, T. Investigation of the medical and social needs of patients in mental hospitals. II Type of accommodation and staff required. *Brit.J.Soc.Med.* 12:23 Jan. 1958.

'Opal 58'—Surprise 'paper evacuation' moves 13 hospitals to nontarget area

(Continued from page 53)

delivered promptly at 9 a.m. the morning of December 2 by a uniformed patrolman, and only to the administrator or his authorized deputy.

This method of delivery had its effect. Within minutes, each of the 13 hospitals had assembled its key personnel, had distributed the questionnaires and had begun its "paper evacuation."

One hospital took less than 30 minutes to complete the paper work. The earliest return was postmarked at 11 a.m., two were postmarked at 11:30 a.m. and three more were postmarked at noon. All 13 were received by the hospital council the following morning, and none was postmarked later than 3 p.m. the previous day, a compliment to the efficiency not only of the hospitals, but also of the Cincinnati post office.

REPORT ON "OPAL 58"

When all hospitals had reported there were 4202 patients in the hospitals at time of the evacuation. Of these, 1636 were ambulatory, 2568 were nonambulatory, 379 required isolation, 510 were too ill to move and 1300 could be discharged immediately. A total of 2394 were to be moved to Miami.

There were 519 physicians, including residents, interns and fellows, 511 registered nurses, 374 practical nurses and 226 technicians in various categories. In addition, there were 13 administrators, 13 pathologists, 15 purchasing agents, nine medical staff chiefs, 11 central supply chiefs, 16 directors of nursing, 39 dietitians and 22 pharmacists.

For the 2394 patients and others making the move, there were three days' supply of perishable foods, 57 days' supply of nonperishable foods, 7 days' supply of intravenous solutions, 12 days' supply of perishable medical supplies and 58 days' supply of nonperishable medical supplies.

Because of icy roads and other traffic and transportation problems it was estimated that the actual move, although only 40 miles, would have taken about 30 hours.

At 2:42 p.m. on December 5, three and a half days after the evacuation order had been received by the hospitals, the wailing of sirens indicated that the theoretical "attack" was under way and a five megaton weapon was theoretically exploded at 12,000 feet over a heavily populated area about three miles from the center of downtown Cincinnati. The radius of total destruction for such a weapon is calculated at 3.1 miles; the radius of minimal destruction, at 9.4 miles. Had such an attack actually taken place, every hospital involved in the move to Miami would have been within the radius of total destruction.

The "paper evacuation" had been completed and the major long-term medical facilities for nearly one million people had been preserved from the "paper attack" in the "move to Miami." ■

(Clip and Mail)

HOSPITALS, Journal of the American Hospital Association
840 North Lake Shore Drive, Chicago 11, Illinois

Please schedule the following advertisement for the _____ issue(s) of HOSPITALS
(Date of Publication)
under the following heading:

_____For Sale _____Instruction _____Positions Wanted

_____Positions Open _____Services _____Wanted

_____

_____

_____

_____

☐ **Check or Money Order Enclosed**

☐ **Bill the Hospital**

Signed_____

Title_____

Hospital_____

Address_____

City & State_____

THE U. S. TREASURY SALUTES THE RAILROAD INDUSTRY

—and its thousands of employees who help strengthen America's Peace Power by buying U.S. Savings Bonds

Each year our railroads carry some half a billion passengers and 2½ billion tons of freight. Railroad employees, who keep this vital transportation system running, help in another substantial way to support our national security. Thousands upon thousands of them are buying U. S. Savings Bonds, regularly, through the Payroll Savings Plan.

Regular purchases of Shares in America aid these thrift conscious people in building up their own reserves for the future. The Payroll Savings Plan provides a sound, systematic way to help finance homes, education and increase security after retirement.

Has your company put in a Payroll Savings Plan? If not, start now! A telephone call to your State Savings Bonds Director will bring prompt and understanding help in putting the Plan to work. Call him now. Or write Savings Bonds Division, U. S. Treasury Department, Washington, D. C.

WESLEY J. HENRY, experienced engineer with one of America's great railroads, is typical of thousands of highly trained employees in this field who are buying U.S. Savings Bonds regularly. Mr. Henry uses his company Payroll Savings Plan to make a personal contribution to the Peace Power of his country.

HOSPITALS
Journal of the American Hospital Association

THE U. S. GOVERNMENT DOES NOT PAY FOR THIS ADVERTISEMENT. THE TREASURY DEPARTMENT THANKS, FOR THEIR PATRIOTISM, THE ADVERTISING COUNCIL AND THE DONOR ABOVE.

prn

PRO RE NATA

JOHN H. HAYES

At the suggestion and with the collaboration of Frank Adae of the Tennessee Hospital Service Association, the following descriptions are submitted.

When Sam Foss wrote "Let me live in my house by the side of the road, etc.", he might have been thinking of working in a hospital. That is where you really meet all kinds of people. For instance:

MRS. NOUVEAU RICHE. (Who grew up on the wrong side of the tracks and would like to forget it.) Nothing is too good for her. In fact, nothing is good enough. If her nurse's call is not answered pronto she asks for the administrator. The food is abominable, the room is dirty and the ice water is warm. Doesn't like the hospital and threatens to discontinue her annual subscription ($10).

SARAH HEARTBURN. The dramatic type. Nobody has ever suffered as does she. Believes her ailment to be entirely new to medicine; and incurable. Has practically no pain, but gives plenty to others.

MRS. R. E. PEATER. Counts any year without at least two hospital stays as a total loss. Thinks Blue Cross wonderful. Knows all about medicine and surgery; and lets everyone know she knows. Has had every physical test but not mental.

PRETTYBOY WOLF. Likes nurses and thinks himself God's gift to them. Feeling is not mutual. He fails to realize how unattractive a man can be in a hospital gown.

BRIDGE CLUB MEMBER. (Usually found in small town hospitals.) Always on the alert to learn something about the nurses, doctors and neighboring patients. Considers spicy items the equivolent of grand slams at the bridge table.

THE FRIEND OF THE PRESIDENT. Seeks more and more privileges and lower charges. Wants to stay unnecessarily long, to keep away from his wife at home. Constantly threatens to tell his friend, the president, of lack of service. When his doctor tells him that he has asked the president to call on him this patient quickly signs himself out. The president never heard of him.

THE SMUGGLER. When told what she must not eat or do she immediately asks her family and friends to bring in sweets, cigarettes and other proscribed articles. When her recovery is thereby delayed she blames her doctor, the nurse and the hospital.

But, in spite of such occasional difficult people, we —like Sam Foss—want to live in our house by the side of the road and be a friend to man.

Collecting Bills and Protecting Good Will...

... problems every hospital administrator faces

Stretching income to cover the costs of improved service and safeguarding the reputation of the hospital can be real problems.

Like many personal service businesses, hospitals are constantly under fire because of rising expenses. How a hospital handles its collections can be an excellent target for criticism—defamatory fuel for an explosive issue. The methods used for *collecting bills can add to or detract from your whole public relations program!* But there is a right way . . .

Allow ACA members to assume your collection responsibility. They provide ethical, dependable service—*always in the best interest of maintaining the good will and integrity* of the institution.

There are ACA offices serving 2,000 communities in all 50 states, Canada and some foreign countries. For full information write this office—or look for the name of your ACA member collection agency in your telephone directory.

"An International Association of Modern Collection Agencies"

AMERICAN COLLECTORS ASSOCIATION Inc.

5011 Ewing Ave. So.
Minneapolis 10, Minnesota

CLASSIFIED ADVERTISING

FOR SALE

Proprietary modern 18-BED GENERAL HOSPITAL in Western Washington, town of 2000, serving area of 13,500 population which is expanding rapidly. Established 50 years. New Building 1958. Service base of 50 beds, already needing expansion. New equipment. Organized medical staff of 7 doctors. This institution will stand meticulous investigation from every aspect and its administration is on highest level of principle. Institution is profitable for private operation, but area and conditions are ripe for conversion to non-profit organization to take advantage of funds available for expansion, tec. Inquiries must be confidential to start to avoid embarrassment of excellent public relations. Address HOSPITALS, Box J-38.

MICROFILM LABORATORY REPORT SLIPS: "Micro-Seal" lab slips can be microfilmed from fully visible slips, six at a time, without lifting or removing each slip. Write for information and samples from The Steck Company, Box 16, Austin 61, Texas.

ADDRESSOGRAPH-GRAPHOTYPE MODEL 6153: for metal plates 5 line, manual. Purchased June 1957. Like new. Cost $577.50. Reasonable offer considered. Walter M. Gray, P.A., Massachusetts Memorial Hospitals, 750 Harrison Avenue, Boston 18, Mass.

BIRTH CERTIFICATES: Your individualized birth certificates at standard stock form prices. Includes illustrations of your hospital. Available in several sizes in blue, pink, and/or white. Write for information and samples from The Steck Company, Box 16, Austin 61, Texas.

INSTRUCTION

PRATT INSTITUTE
offers program leading to
B.S. Degree in Professional Foods
Training for executive careers in management of food services for public and private hospitals and institutions.
Founded 1887
Coeducational • Placement Service
For Catalog B2
Write PRATT INSTITUTE
Brooklyn 5, N. Y.
or Phone MAin 2-2200, Ext. 265

WANTED

Expanding firm with first-class connections with U.K. Hospitals would like to represent manufacturers of PLASTIC LABORATORY WARE, latest gas sterilization apparatus, etc. References available. B. Lipman (plastics) LTD., 298 Wightman Road, London, N. 8.

POSITIONS OPEN

NURSE ANESTHETISTS: for 220 bed community hospital. Working with private group. Two full time M.D.'s, four Nurses, all Agents & Techniques. Modernization program going on. Two and one-half hours from Boston & New York. Write G. J. Carroll, M.D. William W. Backus Hospital, Norwich, Connecticut.

A.S.C.P. REGISTERED MEDICAL TECHNOLOGIST: Male or Female required immediately for an 85-bed, rural J.C.A.H. Approved General Hospital, situated midway between Pittsburgh and Harrisburg; famous resort area. Salary Open, Apply Memorial Hospital of Bedford County, Bedford, Pennsylvania, or telephone the Director, Bedford 655.

DIRECTOR OF NURSING SERVICE: Attractive salary. Beautiful location on Mississippi River. Permanent appointment. Excellent assistant directors supporting position. Degree in nursing required. Apply to Stanley L. Sims, Administrator, La Crosse Lutheran Hospital, 1910 South Avenue, La Crosse, Wisconsin.

DIETITIAN: Immediate opening for ADA registered hospital trained person to direct dietary program in 115 bed JCHA approved general hospital. Diploma school of nursing of 50 students. Desirable personnel policies and salary. Contact J. E. Janzen, Administrator. Naeve Hospital, Albert Lea, Minnesota.

NURSE ANESTHETIST: 40 bed hospital, Southern West Virginia, Salary open. Address HOSPITALS, Box J-32.

EXECUTIVE HOUSEKEEPER I $391-$491, Immediate position available in 135 Rehabilitation Center. Required education and experience equivalent to total of 4 years. EXECUTIVE HOUSEKEEPER II $439-$549, immediate position available in General Hospital. Requires education and experience equivalent to total of 5 years. Requirements refer to combination of education in home economics, Nursing, institutional housekeeping, hotel management or experience comparable to assistant housekeeper on a large hospital or hotel. Contact San Mateo County, Civil Service Commission, Court House, Redwood City, California.

Positions available HEAD NURSES and STAFF NURSES day, evenings and nights. Differential salary for evenings and nights. Salary commensurate with experience and educational background. Generous personnel policies. School of Nursing affiliated with local community college. Modern round wing opens in fall. Located near New York. Starting salary for Staff Nurses is $315. Starting salary for Head Nurses is $380 for somone with a B.S. Starting rate for others is $345. Address HOSPITALS, Box J-26.

EDUCATIONAL DIRECTOR: December 1st. or earlier, for accredited School of nursing; 270 beds modern, accredited, general hospital and teaching institution for interns, residents, X-Ray and Laboratory Technicians. School affiliated with Oberlin College and Metropolitan City Hospital for Specialties. Progressive community near Universities. Excellent personnel policies. Salary commensurate with degree and experience. Write Director of Nursing, Elyria Memorial Hospital, Elyria, Ohio.

SUPERVISOR: Operating Room, also openings for GENERAL DUTY REGISTERED NURSES, 85 bed hospital, fully approved by Joint Commission Western Pennsylvania, situated in famous resort area, attractive salary, liberal personnel policies. Apply to Mrs. E. Thompson, R.N., B.S., Director of Nursing, Memorial Hospital of Bedford County, Bedford, Pennsylvania.

EXECUTIVE HOUSEKEEPER: 180-bed General hospital in Omaha, Nebraska. 5-day, 40-hour week. Paid vacation, sick leave, paid holidays. Salary in line with training and experience. Write to Personnel Director, Immanuel Hospital, 36th and Meredith Streets, Omaha 11, Nebraska.

SURGERY NURSES: must be experienced. Beautiful 83 bed hospital in Los Angeles suburb. Excellent salary and working conditions. 5 day week. Administrator, San Gabriel Valley Hospital, 115 E. Broadway, San Gabriel, California.

ADMINISTRATOR ASSISTANT or BUSINESS MANAGER: M.S.H.A. or equivalent hospital experience necessary. Front office work. Small general hospital. Reply to Administrator, Capitol Hospital, 1971 West Capitol Drive, Milwaukee, Wisconsin, Hilltop 4-1400.

DIRECTOR OF NURSING SERVICE: for 238 bed J.C.A.H. approved general hospital, Pacific Coast resort community. Requires B.S. degree, applicants with experience preferred. Direct inquiries to Rodney J. Lamb, Administrator, Santa Barbara Cottage Hospital, Santa Barbara, California.

INSTRUCTOR: 150 bed hospital with a student body of 70 students. Modern facilities. Located in central Pennsylvania. Must have degree. Good Salary to start. Please send background information and salary wanted, to the Clearfield Hospital, Clearfield, Pennsylvania.

PHYSICAL THERAPIST FOR EXPANDING DEPARTMENT: Excellent opportunity for a qualified person. Pleasant working conditions and liberal benefits. Salary commensurate with experience. Reply giving training, experience and salary required. Mr. Cercie, R.P.T., Brockton Hospital, 680 Centre Street, Brockton, Mass.

NURSE ANESTHETIST, ADMINISTRATOR: 26 Bed, Modern Hospital, College Town. Apply: Secretary of the Board, Crete Municipal Hospital, Crete, Nebraska.

DIRECTOR OF NURSES and SCHOOL OF NURSING: with several years experience and Masters Degree. 465 bed hospital. Excellent personnel policies. Salary open. Write Superintendent, Norfolk General Hospital, Norfolk 7, Virginia.

PSYCHIATRIST for State Hospital. Board Certified or eligible. Salary $16,000 to $20,000 depending on experience and qualifications. New 3 bedroom, unfurnished home available, at nominal cost on hospital grounds, utilities included. Moving expenses will be considered. Contact: Superintendent, State Hospital, Jamestown, North Dakota.

DIETITIAN: ADA member, Therapeutic or Administrative, for 325 bed hospital in western suburb 16 miles west of Chicago's loop. Well equipped Dietary Department. Regular hours. 1 month vacation and other liberal benefits. Salary commensurate with ability. Apply Miss M. L. Schoeneich, Chief Dietitian, Memorial Hospital, Elmhurst, Illinois.

DEPARTMENT HEAD POSITIONS OPEN: Director of Nursing; Controller; Housekeeper; Medical Records Librarian; Operating, Delivery, Emergency, Central Services Supervisors; and Other positions open. Will open late 1959, 183 beds: Additional 132 beds later. Write: Personnel Department, Baptist Memorial Hospital, 6601 Rockhill Road, Kansas City 10, Missouri.

DIRECTOR OF NURSING EDUCATION: for long established hospital affiliated School of Nursing in Pacific Coast resort community. N.L.N. provisional accreditation. M.S. degree desirable, applicants with experience preferred. Direct inquiries to Rodney J. Lamb, Administrator Santa Barbara Cottage Hospital, Santa Barbara, California.

SUPERVISING NURSE, 30-bed hospital Pension plan, hospitalization group, active surgical teams. Position open immediately. Salary range open, dependent upon background. In upper midwest area. Address HOSPITALS, Box J-35.

NURSE ANESTHETIST: Fully qualified, experienced preferred. Work with two others, rotating call duty under board anesthesiologist. 116-bed hospital, 30 miles northwest of Pittsburgh. Starting salary $375 to $400. Contact T. F. Kaap, Administrator, Beaver Valley General Hospital, New Brighton, Pennsylvania.

OUR 63rd YEAR

WOODWARD MEDICAL PERSONNEL BUREAU
FORMERLY A.Z.N.C.B.
185 N. Wabash-Chicago, Ill.
RAndolph 6-5682

Ann Woodward offers her long established, strictly confidential service to hospital administrators, physicians, nursing executives and others wishing to relocate in the medical and hospital fields. Opportunities throughout America and abroad. To the institution reorganizing or augmenting its staff, brochures of those qualified to head medical and ancillary departments or for staff posts will be submitted immediately upon request.

THE MEDICAL BUREAU
M. Burneice Larson, Director
900 North Michigan Ave.
Chicago 11, Illinois

To physicians, hospital administrators, nursing executives and others in the hospital and medical fields confronted with the delicate but important problem of relocating, the physician in need of an associate, or the institution reorganizing or augmenting its staff, Burneice Larson offers the services of the Medical Bureau, All negotiations strictly confidential. Opportunities in all parts of America, including countries outside continental United States.

POSITIONS WANTED

CERTIFIED REGISTERED NURSE ANESTHETIST: male, desires opportunity to take charge anesthesia department, small community hospital, fee-for-service basis. Experienced in all types anesthetics and techniques. Excellent recommendations. Address HOSPITALS, Box J-37.

PATHOLOGIST—board certified, early 40's; desires relocation in active, progressive 150-200 bed hospital. Ohio, Pennsylvania or New England. Address HOSPITALS, Box J-34.

ADVERTISER'S INDEX - - - - AUGUST 16, 1959

Abbott Laboratories 22, 23, 24, 25, 26
American Collectors Association, Inc. 110
American Cyanamid Company
Surgical Products Division 18
American Gas Association 82
American Laundry Machinery Co. 70, 71
American Sterilizer Company 20, 21
Armour Pharmaceutical Company 92

Bard, Inc., C. R. 11
Bates Fabrics, Inc. 69
Bauer & Black
Division of the Kendall Company 34, 35
Baum Company, Inc., W. A. 13
Baxter Laboratories Inc. . .Third Cover, 95, 96, 100, 101
Bay West Paper Company 27
Brillo Mfg. Co., Inc. 33
Bristol-Myers Company 60

Chesebrough-Pond's Inc. 107
Classified Advertising 111
Colonna, Inc., Angelo 93
Cutter Laboratories 59

Deknatel & Son Inc., J. A. 10
Dri-Heat Food System, Inc. 85

Eastman Kodak Company 63
Eaton Laboratories 7
Eichenlaubs 106

Flex-Straw Company 87
Florida Citrus Commission 29
Franklin Research Company 6

Geerpres Wringer, Inc. 30
General Electric Co.
X-Ray Department 12
Goodrich Industrial Products Co., B. F. 4
Gudebrod Bros., Silk Co., Inc. 91, 104, 106

Hausted Manufacturing Company .....Second Cover
Hill-Rom Co., Inc. 31
Hospitals, Journal of
the American Hospital Association 103, 108
Huntington Laboratories Inc. 73, 75, 77, 79, 81

Kayser-Roth Hosiery Co., Inc.
Div., of Kayser-Roth Corp. 28
Kent Company, Inc., The 37

Lehn & Fink Products Corp. 38
Lilly & Company, Eli 2

Minneapolis-Honeywell
Regulator Company 8, 9
Minnesota Mining & Mfg., Co. 1

Orthopedic Frame Company 32

Parke, Davis & Company .....Fourth Cover
Patton Hall, Inc. 91
Perry Rubber Company 105
Procter & Gamble Company 14

Royal Metal Manufacturing Co. 19
Royal McBee Corp. 99

Savings Bond 109

Technical Equipment Corp. 67
Travenol Laboratories, Inc.
Pharmaceutical Products Division
Baxter Laboratories Inc. 95, 96, 100, 101
Tykie Toy, Inc. 104

West Chemical Products, Inc. 15
Winthrop Laboratories 16
Wyeth Laboratories 5

PICTURE CREDITS

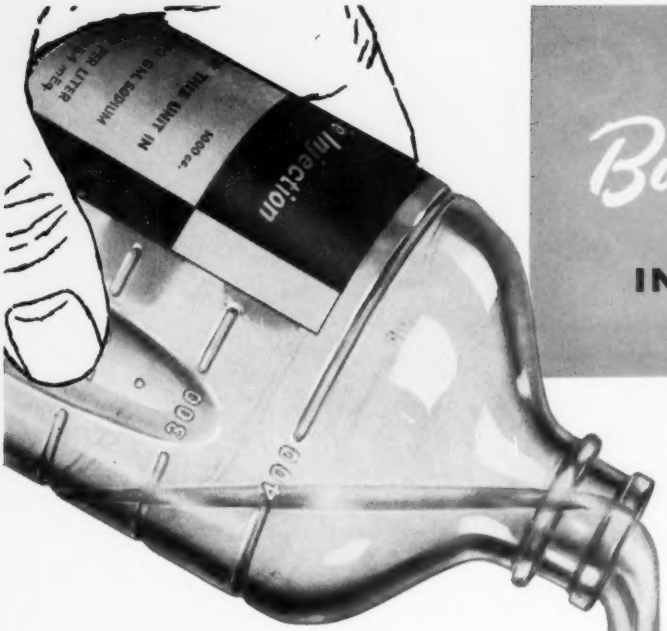
p. 30 Greenwich Time Photos

p. 47 UPPER: Keith's Studio
LOWER: World Wide Photo

p. 55 UPPER LEFT: Paul E. Robinson
UPPER RIGHT: Anderson Photo Co.
LOWER RIGHT: Anderson Photo Co.

p. 56 RIGHT: Anderson Photo Co.

p. 57 LOWER: Anderson Photo Co.



Busiest Bottle

IN ANY HOSPITAL

From O.R. to Nursery . . . from Pharmacy to Emergency Room . . . wherever sterile, distilled water, normal saline and irrigating solutions are used, this modern pour bottle is on hand. Functional design, convenient screw cap, and sure-grip finger grooves are among the basic reasons for its growing preference.

These liter-size pour bottles conserve hospital time . . . reflect direct savings in fluid preparation, material costs, labor costs, overhead costs. Control and safety factors are constant . . . while present equipment may be freed for other uses.

Pour bottles are finding increasing use for irrigation and other washing and rinsing procedures in the OPERATING ROOM . . . for rinsing and preparation of syringes, needles and other I.V. equipment in CENTRAL SUPPLY . . . in the preparation of small R_X items in the PHARMACY . . . for preparation of specific diets in the INFANT FORMULA ROOM . . . as a source of sterile water and saline for washing and rinsing in the NURSERY . . . at NURSING STATIONS . . . in the OUTPATIENT DEPARTMENT . . . in the DELIVERY ROOM . . . in the EMERGENCY ROOM.

For these uses, and for *re-use* functions of the bottle itself, more and more hospitals are standardizing on this most versatile unit.

NOW AVAILABLE IN MULTI-USE POUR BOTTLE

Cat. No. G94	DISTILLED WATER
Cat. No. G104	NORMAL SALINE
Cat. No. G124	UROLOGIC SOLUTION G Irrigating solution for dissolution of urinary tract calculi
Cat. No. G134	GLYCINE 15% IN WATER Urologic irrigating solution.

BAXTER LABORATORIES, INC. MORTON GROVE, ILLINOIS

DISTRIBUTED AND AVAILABLE ONLY IN THE 37 STATES EAST OF THE ROCKIES (except in the city of El Paso, Texas) THROUGH

AMERICAN HOSPITAL SUPPLY CORPORATION

SCIENTIFIC PRODUCTS DIVISION GENERAL OFFICES • EVANSTON, ILLINOIS

University Microfilms
313 North First Street
Ann Arbor, Mich. C

stops

post-operative oozing

Absorbable Hemostatic

Time-tested OXYCEL (oxidized cellulose, Parke-Davis) promptly achieves surgical hemostasis following capillary and other small-vessel bleeding. Applied directly from the container, OXYCEL readily conforms to wound surfaces.

■ Sterilized, gauze-type, 3 inch x 3 inch eight-ply pads, and 4 inch x 12 inch eight-ply pads.

▬ Sterilized, cotton-type, 2¼ inch x 1 inch x 1 inch portions.

▬ Sterilized, four-ply, gauze-type strips, 5 inch x ½ inch; 18 inch x 2 inch; 36 inch x ½ inch; and 3 yard x 2 inch, pleated in accordion fashion.

▲ Sterilized, four-ply, gauze-type discs, 5 inch and 7 inch diameters, conveniently folded in radially fluted form.

Supplied in individual glass containers.

PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN

Especially effective when used preoperatively

adrenosem®*

SALICYLATE

(Brand of carbazochrome salicylate)

to control oozing and bleeding

As one clinician states: "Blood loss may be hidden temporarily after closure of the thoracic or abdominal cavities, even though drains are in place. Obstruction to outflow through these drains can occur, and bleeding is not apparent.

"There are certain clinical situations in which prolonged and profound oozing of blood may occur."

Adrenosem has proved effective in more than 200 clinical disorders in the control of oozing and bleeding. It is used routinely, preoperatively and postoperatively, in thousands of hospitals.

Supplied in ampuls, tablets and as a syrup.

Write for comprehensive, illustrated brochure describing the action and uses of Adrenosem Salicylate.

*U.S. Pat. 2581850; 2506294

1. Drippe, R.C.: Hazards of the Immediate Postoperative Period, J.A.M.A. 7:795 (Oct. 19, 1957). [This reference reviews postoperative hazards, and does not refer to Adrenosem Salicylate].

BRISTOL, TENNESSEE • NEW YORK • KANSAS CITY • SAN FRANCISCO

THE S. E. MASSENGILL COMPANY

more than
3000 hospitals
coast-to-coast
are participating
in the Senokot® hospital
sample program

evaluate **Senokot®** TABLETS GRANULES
for all constipation problems
in your hospital...
now...at no cost or obligation.

Join The **Senokot** Hospital Sample Program

- Save Nurses' Time by Drastically Reducing the Need for Enemas
- Avoid Patient Discomfort
- Attain Excellent Patient Acceptance
- Enjoy the Time-Saving Benefits of Easy Administration

GENTLEMEN: Please enroll us in the 'Senokot' Hospital Sample Program at no cost or obligation.

We would like ☐ 'Senokot' Granules (¾ ounce canisters)
☐ 'Senokot' Tablets (vials of 12)

for the treatment of _____ patients per month.

Please state No. of: beds _____ bassinets _____ deliveries annually _____

NAME OF HOSPITAL

ADDRESS

CITY ZONE STATE

SHIP ATTENTION OF

AUTHORIZED BY TITLE

4590

natural bowel corrective

Senokot® TABLETS / GRANULES

STANDARDIZED CONCENTRATE OF TOTAL ACTIVE PRINCIPLES OF CASSIA ACUTIFOLIA PODS, PURDUE FREDERICK

reduces enemas 84%[1]

SPARES NURSING STAFF: Kasdon and Morentin report that the "...normal woman post partum rarely has a spontaneous stool in the first few days of the puerperium."[1]

The authors also report that this presents "...an economic and administrative problem in the obstetric departments of most hospitals, since the shortage of nursing personnel makes it undesirable to employ enemas...requiring fifteen to twenty-five minutes of...time for each patient."[1]

The same authors show that 'Senokot', a standardized concentrate of total active principles of Cassia acutifolia pods resulted in spontaneous bowel movements "...in 84 per cent of the women by the third day after delivery" as compared to 13 per cent where no cathartics were used or 16 per cent where milk of magnesia and mineral oil were used by the third day after delivery.[1]

This means an inestimable savings in money and precious hours among nurses and orderlies, thus freeing them for other more important duties.

SPARES PATIENT DISCOMFORT: Unquestionably, patients prefer laxative therapy for constipation correction the 'Senokot' way, which is always a safe and pleasant experience, predictable in results, and quite personal, *involving the patient alone.* 'Senokot' enjoys complete patient acceptance, spares patients the griping and sudden urgency of harsh chemicals, the nutrition-filching and hospital linen-staining properties of mineral oil and the unpredictable features of cascara. 'Senokot' is clinically preferred as ideal for hospitalized patients.

Effectiveness and safety of 'Senokot' have been documented by clinical and laboratory investigations which constitute the fastest growing bibliography on constipation correction.

'SENOKOT' HOSPITAL SAMPLE PROGRAM: Purdue Frederick will supply, to any *new* member now joining the 'Senokot' Hospital Sample Program, whatever quantities of 'Senokot' Granules or 'Senokot' Tablets your hospital will require as often as needed, for a minimum period of six months.

Your allotment will arrive with two free 'Senokot' samples for each patient *who requires laxative therapy during hospitalization.* The first sample the patient takes *in the hospital,* as his physician directs. The second sample, which the nurse gives him upon discharge, he carries *home.* This is important because after most operative and post partum procedures, the patient will require additional laxative therapy at home. The "hospital" sample, therefore, introduces the patient to 'Senokot' and the "home" sample will help him start on 'Senokot' as soon as his physician directs.

SUPPLY AND DOSAGE:

TABLETS: Small and easy to swallow, in bottles of 100 and 30. 2 to 4 tablets nightly.

GRANULES: Cocoa-flavored, in 8 and 4 ounce canisters; also available in special 1 ounce hospital canisters. 1 to 2 level teaspoonfuls nightly; for children, ½ to 1 level teaspoonful nightly.

REFERENCE:

1. Kasdon, S. C., Morentin, B. O.: J. Internat. Coll. Surgeons 31:455 (April) 1959.

POSTAGE WILL BE PAID BY ADDRESSEE

NO POSTAGE STAMP NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL

First Class Permit No. 62786, New York, N. Y.

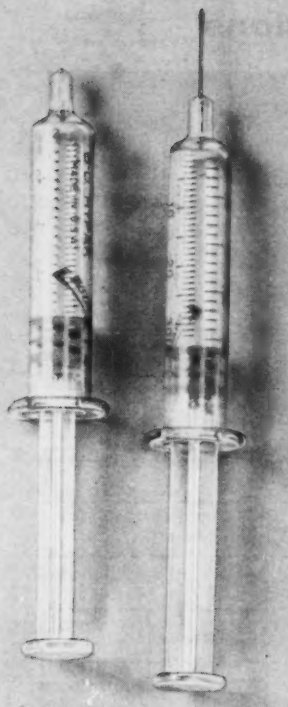
THE PURDUE FREDERICK COMPANY
135 CHRISTOPHER STREET
NEW YORK 14, NEW YORK

evaluate **Senokot®** for all constipation problems in your hospital now...at no cost or obligation.

it's glass

B-D

HYPAK®

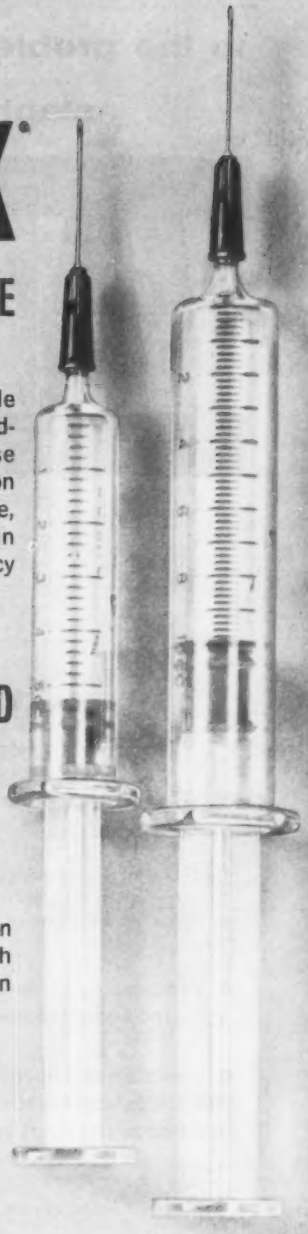


STERILE DISPOSABLE GLASS SYRINGE

B-D HYPAK Sterile Disposable Syringes are the only such products made of glass. Because glass represents a true extension of the manufacturer's package, parenteral medications retain their purity, potency and efficacy in HYPAK.

NOW IN A WIDER RANGE OF SIZES AND STYLES AND...SAFE AS ONLY GLASS CAN BE

B-D HYPAK is now available in 2 cc., 5 cc. and 10 cc. sizes—with or without needles—graduated in minims and cc's.



a B-D DISCARDIT product

B-D

manufactured, sterilized and controlled by

BECTON, DICKINSON AND COMPANY • RUTHERFORD, NEW JERSEY

In Canada: BECTON, DICKINSON & CO., CANADA, LTD., TORONTO 10, ONTARIO

B-D, HYPAK AND DISCARDIT ARE TRADEMARKS OF BECTON, DICKINSON AND COMPANY 74959